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The Journal of The SOUTH CAROLINA Medical Association

VOLUME LI JULY, 1955 NUMBER 7

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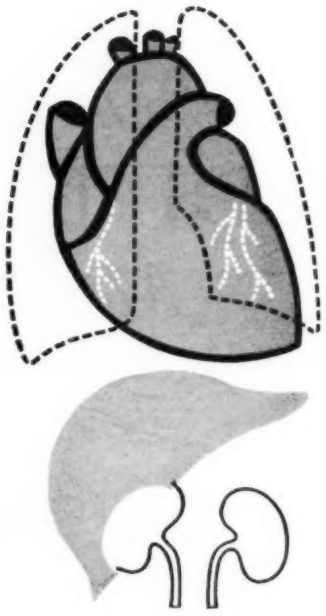

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The Journal
of the
South Carolina Medical Association

VOLUME LI July, 1955 NUMBER 7

MEDICAL COLLEGE HOSPITAL DEDICATION EXERCISES,

MAY 10, 1955

REMARKS BY DR. THOMAS A. PITTS, PRESIDENT OF THE BOARD OF TRUSTEES

On behalf of the Board of Trustees of this institution, I want to thank you for coming and to welcome you. Further, I want to urge you to go through not only the new hospital but the entire plant, including the new dormitory and cafeteria, for after all it is yours. After your inspection I believe you will be pleasantly surprised and favorably impressed, particularly those who are familiar with like institutions in other states.

This institution, like so many others of its kind received help and encouragement from many sources. To name a few, I will start with the South Carolina Medical Association, The Alumni Association of this institution, The City of Charleston, The Charleston County Council, many federal agencies, particularly from the U. S. Public Health Authorities and the administrators of the Hill-Burton law, The South Carolina Board of Health, the South Carolina Hospital Commission and numerous others. In fact we sought aid and advice often and from many quarters and never received a serious rebuff. But let it be recorded that the appropriating bodies of the State Government have been most considerate.

After years observation of the General Assembly of our state, I am convinced that it does a wonderful job. You can depend on that body arriving at a correct conclusion, once they have all of the facts. With the tremendous pressures put on them from many sources for tax money and all with plausible reasons while the man in the street is howling about taxes, I express my admiration and my sympathly for the members of the legislature. I would not trade places with any one of them.

This institution came into being in a co-operative effort from many sources.

This Board recognizes its responsibilities to the state as a whole and the main purpose is to educate doctors and allied personnel. If this institution fails to turn out more and better educated people in this field, then the whole purpose of these millions will have been lost. In doing this, our studied and planned aim is not to interfere with the well ordered course of individuals or institutions in this area or in the state as a whole.

The Medical College has been closely associated over many years with the Roper Hospital to the mutual advantage of each. We hope this will continue and grow. The new Medical College Hospital is not replacing the teaching facilities now offered by the Roper Hospital. The new hospital is to supplement and not to replace. It is hoped that a state of synergistic symbiosis can be attained and maintained.

The most important duty of any Board is to find and employ the right people. In the early forties when World War II brought into sharp focus the great need for medical technologists and technicians, we began to search for someone to carry out a much needed expansion program. The board unanimously chose Kenneth M. Lynch, then Professor and head of the Dept. of pathology and placed him in charge of the entire program. This has proven

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to be a wise choice.

It appears proper at this time for me to point out a few facts about the head of this institution. He is Texas born, a South Carolinian by choice. He was educated at the University of Texas and at the University of Pennsylvania. He was an instructor in pathology at the University of Pennsylvania in 1912 when he was induced to come to Charleston as the first full time professor ever to be employed by this institution. He has headed the Department of Pathology ever since. He has found time to do research of great renown. He has received citations from many sources, including the Gold Medal for Scientific Research from the American Medical Association. This has been accomplished by only one other South Carolinian and that was in the nineteenth century. He also received a medal for research accomplishment from the Southern Medical Association. He is the author of two widely accepted textbooks, one of which is re-printed by permission in England. He has 93 professional papers in scientific publications and properly indexed. His mental powers have been recognized by other institutions. He has received an Honorary Degree of LL.D. from the University of South Carolina. He also received a Doctor of Laws degree from the College of Charleston. He was one time Vice-President of the American Medical Association. He is a past president of the South Carolina Medical Association. He is a past chairman of the Executive Committee of the State Board of Health. His accomplishments are so numerous until they cannot all be mentioned but if you will refer to "Who's Who" in America, you will find out perhaps some surprising things about the man that we chose as our leader. I am sure that if this Board was again faced with the task of choosing a person to head the institution, the same man would be again unanimously chosen but with far greater enthusiasm, if such were possible. So it is with real personal pleasure and pride that I present to you at this time one of the great physicians of our day, our professor, our teacher, our researcher, our diplomat, our leader, our president, Kenneth M. Lynch.

DR. KENNETH M. LYNCH, PRESIDENT, PRESIDING, REMARKS

Governor Timmerman, Mr. Chairman, distinguished guests and friends of the Medical College of South Carolina:

As you will of course realize, it has not been possible for us to encompass in one event acknowledgment of our indebtedness and appreciation even to any considerable part of the many persons who individually or as members or officials of organizations, societies, governments, agencies and groups of various types have played essential roles in the development of the medical educational, research and service center of South Carolina during the period of the effort dating from January 1944.

We shall have to trust that all of the hundreds of persons whose names we would like to call as direct participants—from those who worked here to all of those along a route that had to be explored and opened—that all of these will believe that our heart is big enough to hold the thankfulness we feel to each.

Perhaps the story and its characters represent what we call the "American" way. I believe, too, that what we are today calling the dedication of a building—a great new hospital, built for service to people—carries farther than that simple caption. Truly, we mean to express the dedication of the lives of the people for whom this hospital and the other physical parts of the Medical Center will provide places and tools for the work involved in doing that service. While working places and things are essential, the product of this enterprise is entirely in people.

The accomplishment which we are today exposing to you as simply a step toward completion that can never become concluded has been done in a manner out of the usual course. In a sense it was undertaken in the hard way, which is to say perhaps, the best way; possibly it was the only way for success here. In the few credits that we may enter at this time, may I take the liberty of saying that a task which elsewhere has usually required an additional and special organization to do has been entirely and solely accomplished here by the regular teaching organization. Dr. Weis-

kotten, you will know what that has meant and what that proves.

The course was carefully and fully surveyed and charted; to this day it has not been changed. It is significant that there has been no retraction nor any alteration even of the phrases used in launching what was at first called the Expansion Program, and what has matured into a modern medical center.

It was realized that the first territory through which we must pass was the home territory, that in our own professional area we would be subject to the closest scrutiny, and that we must be *right* to pass that critical examination. At our request the South Carolina Medical Association set up a commission to survey our program, and in receiving the report of that commission at a special called meeting gave its unanimous stamp of approval.

The Medical College Alumni Association was also called upon; it has given unfaltering support all the way, and has contributed in such a material way as to make possible the provision of the students' residence called Alumni Memorial House and of a large part of the land that will compose the completed campus.

The South Carolina Medical Association has honored us by meeting here during this time in order to be present at the formal dedication of the program that it sponsored. As the representative of the Association, and of the medical profession at large, I am pleased to call upon the president of the Association, Dr. Thomas R. Gaines, of Anderson.

Dr. Gaines—

Dr. Lynch, Governor Timmerman, friends of the Hospital and the Medical School:

Some years ago while doing post-graduate work at a Midwestern University, I was impressed with the wealth of clinical material in the teaching hospital associated with the University. I was only one of many physicians from all over this country who sought out this institution for increase in the knowledge of medicine. The question came to my mind: "Why am I, a South Carolinian, here instead of learning at home?" I was soon to find the reason — a large, well-equipped hospital, staffed by thoroughly trained teaching physicians with its doors open to the sick from all over the State. Obscure and rare illnesses and difficult cases of all descriptions found themselves there, attracted by the most modern equipment for diagnosis and treatment and by the diagnostic and therapeutic ability of its staff.

Today sees the beginning of such an institution in South Carolina. It means better facilities for treatment for the sick of our State; better training for our young doctors, added attraction for the outstanding teachers to come here, and finally added prestige to our Medical College as a teaching center both for undergraduate and graduate study.

On behalf of the South Carolina Medical Association I extend congratulations and best wishes to you, Dr. Lynch, and to your fellow workers who have striven so zealously for this great accomplishment.

Dr. Lynch—

In the social progress of man, as civilization has produced the modern community — now grown in advanced countries to densely populated societies of hundreds, thousands and even millions of individuals—more and more group activities have become required. Among the first community supported protective services were police and fire departments. Another that became required was the health department. Without this service to develop and apply knowledge of how to protect against the many health hazards, practically nothing that we enjoy today would have become possible. In fact until we learned enough to establish effective community health service, threats of devastation by lawlessness, war or fire were minor as compared to the constant threat of disease—disease that repeatedly depopulated cities and doubtless destroyed whole civilizations—disease about which we are entirely unconcerned today.

Having brought the great destroyers of previous ages under control by concerted effort, local, state and national, we have arrived at the next phase of action against other types of health hazards. Although we believe that the personalized service of a physician to his patient is of such nature that it must remain under the system of direct responsibility and

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professional control, it is obvious that it is beyond the opportunity and the means of any individual to secure by himself the medical care that he may need at any moment; that only through the means of community support can he have at hand at all times the services that have become available to save him from loss of health and life.

Thus we no longer question the right and the responsibility of a community to provide the facilities that would make it possible for each citizen to receive the medical care that the medical profession is prepared to give. In this development South Carolina is at the forefront.

Since ordinarily there are limits, economic and professional, to what the vast majority of local communities may provide, it is essential that health and medical care facilities of a larger scope be provided by an association of communities. Thus comes about the base or regional hospitals, and, further, the great centers for the training of personnel, for the advancement and application of knowledge and for medical care service, for which the term "Medical Center" has come into vogue. It is that keystone of further progress in medical service that we dedicate here today.

Since in many, and perhaps most instances, large sections of the population even of this rich country, would otherwise be left with inadequate medical care, there had to be an enlargement of group support to state and even national participation. Our own investment in land, construction and equipment of the hospital came from city, county, state and federal appropriations.

As the invited representative of the territory of public health as a whole and in appreciation not merely of the contributions but of the cooperative help given by all of the personnel of the state and federal agencies, I am pleased to introduce Dr. John W. Cronin, Medical Director, Chief, Division of Hospital Facilities, USPHS.

Dr. Cronin—

Doctor Lynch, honored guests, ladies and gentlemen.

It is a real pleasure to be with you today and a privilege to bring to you the congratulations and best wishes from Mrs. Oveta Culp Hobby, Secretary of the Department of Health, Education, and Welfare, and from Dr. Leonard A. Scheele, Surgeon General of the United States Public Health Service.

To participate in these dedication ceremonies of the Medical College of South Carolina Hospital is personally very gratifying to me. I had the pleasure of a three hour trip through this hospital this morning. It is a fine institution and one which all of you may well be proud. I know how happy and proud Dr. Lynch must be as he has been actively a part of the planning, design, and construction. We have watched this project since its inception because it is one of the largest projects, dollar-wise and bed-wise, which has come under the provisions of the Hospital Survey and Construction Program. Again, it is one of the urgently needed teaching hospitals which will provide a place of training for physicians, nurses, dietitians, laboratory and x-ray technicians, and others of the health team. The smaller communities and their hospitals are all dependent upon these medical teaching centers for their greatly needed health and hospital personnel.

Since 1946 when the Hospital Survey and Construction Program, popularly known as the Hill-Burton Program, was begun, 2500 hospitals and related health facilities have been approved for Federal aid in construction. Over 1700 projects have been completed and are currently serving their communities. Yet, our nation's hospital shortage is great. It amounts to over 800,000 beds in all types of hospitals—general, mental, tuberculosis, and chronic. Our annual population increase and the obsolescent factors are of such a magnitude that it is about all we, as a nation, can do to just keep up with current demand. We are not appreciably reducing the great deficit in hospital beds which was accumulated during the depression years from 1929 to 1939 and the World War II years.

Medical practice and the methods of medical care is in a constant state of flux. Hospitals such as this one here at the Medical College of South Carolina are the hub, the very center

of these ever-present changes. Your hospital is designed and built to be able to meet economically and effectively the demands of the patient and the staff.

I would like to read to you a few lines written by a former commanding officer in our Service. These words were written by Assistant Surgeon General Fred C. Smith (Retired), U. S. Public Health Service.

"A hospital pays higher dividends in usefulness than any other public building. A department, bureau, agency or court, post office or custom house is open only a third of each twenty-fours and is closed fifty two Sundays and many holidays each year. A hospital is never closed. Its lights are an eternal fire on the altar of service. Its door is never locked; its windows never darkened.

"When vacation grass grows lush on silent school house grounds the hospital knows no respite. While the Cathedral drowses many days each week over empty pews, the hospital vibrates through every crowded moment with never-failing service to humanity. Through long hot summer days and nights, as in winter storm and autumn blast, the hospital carries on. In public disaster, when other enterprise is dazed and crippled, the hospital never fails.

"The best that is in men and women is brought out in the crises that try the soul. In operating room and ward is forged, in the fire of sacrifice and renunciation, the character that ennobles. Pious resignation, courage and generosity are here daily witnessed. To the hospital come both saint and sinner, the victim of wasting disease, of violence or of his own vicious habits. Whether they march to the drums of war or the pipes of peace, the sick and maimed seek refuge where pain is eased and life held sacred and find there, true to hospital traditions, not only scientific efficiency, but tolerance, kindness and understanding sympathy."

To me, these words describe your hospital.

Dr. Lynch—

I doubt that there is any area of the educational world under more effective and sound control than that of medical education. It is a matter of some institutional pride that more than one hundred years ago the faculty dean of the Medical College, Dr. James Moultrie, prophetically proposed to the American Medical Association the improvement of the medical course on the lines that became standard many years later. Further, as recorded by contemporary medical historian J. I. Waring, "In 1840, the faculty of the Medical College opened a 'College Hospital for the purpose of furnishing instruction at the bedside of the sick for medical students and the annual classes' which well may have been the first hospital in America conducted primarily for teaching purposes." It is also a matter of pride that not only did the medical educators of the official organizations of the Council on Medical Education and Hospitals of the American Medical Association and of the Association of American Medical Colleges give our program full approval, after full and critical survey, but that repeatedly they joined and backed us in the campaign to secure it.

As the invited representative of the medical educational world we are honored to have with us the man who has had most to do with the great improvements in this area for a generation. I wish to introduce him not only as former dean of the school of medicine at Syracuse and Chairman of the Council on Medical Education and Hospitals of the American Medical Association, but as the dean of American medical educators—Dr. Herman G. Weiskotten.

Dr. Weiskotten—

It was just twenty years ago last month that it fell to my lot to carry out a detailed survey of all departments of your medical college.

At that time the financial support of the college was entirely inadequate. We were in the midst of a great financial depression and the needs of our medical colleges were attracting far too little attention.

However the interest, loyalty and personal sacrifice of the faculty and the practicing physicians of the community carried the college through this most difficult period.

One of the department heads with whom I was particularly impressed on this initial visit was a young fellow by the name of Kenneth Lynch, who as Professor of Pathology, with a

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single assistant in training, was conducting a very stimulating educational program—all with a total departmental budget of $7,365. In my notes I reported him as an unusually capable man carrying an almost impossible load.

Since that visit I have had frequent and intimate associations with Dr. Lynch and have watched with interest and ever-increasing admiration his efforts and contributions to the development of the college and of a medical center for the State of South Carolina.

Thus it is with much pleasure that on the occasion of the dedication of this hospital I bring to the administration of the college and to the citizens of South Carolina the greetings and best wishes of the Council on Medical Education and Hospitals of the American Medical Association.

Rapid advances in the field of medicine have made well-conducted medical centers essential, not alone for the satisfactory complete medical care of the people but also for the undergraduate and graduate training of physicians and other health personnel and for the advancement of medicine. It is for this reason that the federal government has wisely considered it justifiable to contribute to the development of this and other well conceived medical centers.

When adequately staffed the facilities which you are dedicating today will offer unusual opportunities for the training of general practitioners and specialists.

They offer opportunity for the training of nurses and a variety of other personnel all essential to good medical care.

Furthermore they make readily available to the physicians and citizens of your state highly specialized diagnostic and treatment services which can only be found in well developed medical centers.

In the field of research it is becoming more and more obvious that research leading to advances in the diagnosis, prevention and treatment of disease can not be confined to so-called "Ivory Tower" activities.

It must involve an integration of laboratory experimentation and observational investigation. There is constant need for a flow of ideas, information and activities in both directions between the experimentalist in the laboratory and the physician in the clinic and in the field.

The facilities which you now have with their intimate association with the basic science departments of the medical college will provide unusual opportunities for sound research programs.

Let us hope that the state will see its way clear to adequately support this educational, service and research center to the attainment of its full potentialities.

I wish you every success and happiness in your future development of the center.

Dr. Lynch—

I am sure that it will be no cause for jealousy as to which area of our support should receive the major credit, when I say that the richness of experience has certainly not been the least in our dealing with the political governmental area. From this has come a deep and abiding faith in the American way, by which we manage to secure the services of able and devoted men and women—and an overwhelming thankfulness that this is so. From the acquaintance I have been privileged to gain with those in office during my time, I hold sincere sympathy for them in the trials which are theirs in solving the problems we place upon them—and I have the greatest admiration for the way in which they do this.

It was with sincere regret that we came to realize that at least the present occasion would not provide the opportunity to even call the names of all of those from whom we have learned the meaning of gratitude. They range from the city and county governmental offices through the state legislative and executive areas and on to the halls of congress and the executive mansion at Washington.

We are honored that South Carolina's leader of government and chief executive over this as well as all state agencies has found it possible to join us today and to pronounce for all of us the dedication of this institution to the service of the people. It is a pleasant privilege to introduce the Honorable George Bell Timmerman, Jr., Governor of South Carolina.

Governor Timmerman—

Dr. Lynch, Ladies and Gentlemen:

As we assemble here today, we easily could be awed by what we see around us.

This area, we can well imagine, once was the playground of the tides, a continuation of the marshes and near marshes that are common to the coast.

But in reality it is not a submarginal area. Man with his engineering skill has fashioned here a colony of structures.

Within the sound of my voice are many examples of how man uses muscle and mind, concrete and steel, brick and mortar, to build for himself protection against the elements. These structures have withstood some of nature's mightiest blows, the hurricane, the rain, the lightning and sometimes the oppressive heat of summer. That is a fine record of endurance.

The most dominant among them is the newest, the monument we dedicate today.

Thousands of people travel great distances to view the pyramids of Egypt, the great medieval castles of England, the Arch of Triumph in Paris. These are the products of the toil of man. They, too, are examples of the skill of man as a builder. They draw loud and sincere praise from those people who view them.

But how insignificant they are as compared to this institution which we rededicate today to the service of humanity. A building alone is of little value to man. A building gains meaningful value from the equipment and skills which man carries into the building and places into the service of humanity.

To be awed by the outward appearances of the structures around us would be to forget the humanities and bury ourselves in base materialism.

These buildings because of the uses to which they are put do rank high in our record of achievement. As we are symbols of the success of the practitioners of medical science, so are these buildings and the investment they represent symbolic of our faith in the science of medicine.

Our people, through governmental agencies, religious groups and privately, have made possible, within an area of a few blocks, the construction of five hospitals, an institution for instruction and research in the field of medical science, and such additional buildings as are needed for housing many of the students and staff personnel.

That faith in medical science is not peculiar to our generation.

On January 1, 1824, the State General Assembly granted to the Medical *Society* of South Carolina the authority to organize a medical college. In 1828 the legislature appropriated $10,000 for the college to be augmented later by $7,000.

In 1913 the Medical College faced the need of meeting new standards. More money was required. The legislature on February 8 of that year passed an act transferring ownership of the college to the State and committed the State to the support of medical education as an important branch of its educational system.

This year there has been appropriated for the operation of the College and its new hospital more than 2 million dollars.

In the 135 years of its existence the College has faced many obstacles. Some had the appearance of being overwhelming. Despite these, the College has progressed and continued to meet its responsibilities in the provision of well-trained doctors and nurses for our State.

In reviewing the history of this institution I noticed that on the first faculty were men named Prioleau and Ravenel. In the current catalog, these names are still on the faculty list. Another member of the first faculty was named Frost. That is the given name of one of the present associate professors.

I cite as other examples of the continuity of the College— continued service to the people of our State in the battle against disease and illness; and continued training of young men and women as medical practitioners; as well as continued service and devotion by succeeding generations to the school of their forebears.

As has been our good fortune in many fields, the Medical College has had the services and has contributed to the success of many men of world-wide prominence.

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As a layman, I would not attempt to name them all. Nor would I attempt to assign to each his rank within the group. To do so would be impossible. But from such men we find inspiration to lead us to even higher goals of attainment.

Dr. James Moultrie, Jr., one of the founders of the Medical College, was also one of the founders of the American Medical Association. In 1851 he was elected its president. The main energies of his life were directed to medical education. As president of the American Medical Association he advocated a type of medical education many years before it became widely applied.

Samuel Henry Dickson was the first professor of the practice of medicine here. He later held similar positions at the University of the City of New York and at Jefferson Medical College in Philadelphia. Dr. Dickson contributed a number of textbooks and medical essays to the profession.

Stephen Elliott, a botanist and member of the first faculty, was called the father of the public school system of South Carolina. His work, "A Sketch of the Botany of South Carolina and Georgia" is a classic.

James Marion Sims began his studies here. Dr. Sims later became famous in New York City in the surgical treatment of women's diseases and founded Woman's Hospital, still a successful institution.

Louis Agassiz, Swiss-American naturalist, was considered one of the more able science teachers America has known. For a time, he served as professor of anatomy at the Medical College and established on Sullivan's Island a laboratory for the study of coast fauna.

Dr. Simon Baruch was a student at the Medical College when the faculty and student body left the classroom to shoulder arms in the northern aggression. After service with the Army of the Confederacy and while practicing medicine in New York, Dr. Baruch earned the title, "Father of hydro-therapy in America."

Robert Alexander Kinloch, who joined the faculty in 1866, was the first surgeon to perform successfully many kinds of operations.

Julian John Chisolm, a graduate of the College and a professor of surgery here, was one of the famous surgeons of the Confederacy. He was author of a textbook of military surgery. Later Dr. Chisolm was a member of the faculty of the University of Maryland and in 1877 he founded the Presbyterian Eye, Ear and Throat Hospital of Baltimore.

The greatness of the Medical College of South Carolina does not lie completely in the past. Equipment and facilities have been expanded through the years. The number of trained and specialized personnel has been increased. Private grants have made it possible for more effort to be directed toward success in the cure and prevention of disease. Private grants depend upon work that is meritorious. That such grants continue, and in some instances increase, proves the value of what is being done.

The college is fortunate to have as its president, Dr. Kenneth Lynch. He has been in the forefront in modern medical research. For his research, Dr. Lynch received the gold medal of the American Medical Association and the research medal of the Southern Medical Association. He was a pioneer in the investigation of industrial dust diseases, that led to the elimination or reduction of health and life hazards in many industries. Dr. Lynch is the author of some 91 papers and two books.

Under the direction of Dr. H. R. Pratt-Thomas, professor of pathology, experimental studies are now being conducted into the causes of cancer, and efforts are being made to improve methods for its diagnosis.

Dr. Melvin H. Knisely, professor of anatomy, is directing experimental studies in circulation of the blood.

Dr. Elsie Taber, assistant professor of anatomy, is seeking to determine the influence of glands of internal secretion upon growth.

Dr. R. P. Walton, professor of pharmacology, is directing studies of the effects of various drugs upon the heart and circulation.

Under Dr. T. G. Bernthal, professor of physiology, work is under way on experimental studies of poorly understood processes of respiration.

Associate members of the surgical staff, under Dr. John A. Boone, professor of medicine, are joining in pioneer investigation of the

heart. Improvements are being sought in surgical correction of heart and blood vessel defects.

Under Dr. R. F. Hagerty, assistant professor of surgery, plastic surgical repair is being studied with the goal of improved techniques, particularly in relation to wounds and to defects of the mouth.

On many different fronts, medical science is reporting new success in the diagnosis and treatment of disease. The people of South Carolina are encouraged by these advances.

They hope and believe that the staff of the Medical College will use these increased and improved facilities for even greater success than has been achieved in the past.

The continuing investment which is being made in the Medical College of South Carolina expresses the hope of our people for a continued supply of adequately trained medical personnel.

Adequate medical care is essential to the welfare of the people of our State.

We often point with pride in South Carolina to the development of a public school system as fine as any in the nation. For many years South Carolina has been among the leaders in the development of an adequate highway system. In recent years our industrial growth has been phenomenal. Throughout our State new jobs are being created, better payrolls are being provided, enlarged markets are being developed.

It is necessary that this progress continue. The demands of today necessitate an enlarged economic base in our State.

Only strong minds and strong bodies can meet these demands. South Carolina can not keep pace with her opportunities unless all of her people have access to the best knowledge and skill of medical science.

The health of our people will be determined in large measure by the effectiveness of the men and women of the Medical College of South Carolina. Upon them lies the responsibility for training medical practitioners.

The basic purpose for the existence of this medical college and this magnificient new teaching hospital is the production of well-trained medical personnel. We must not rest on our laurels until adequate medical care is available for all our people.

In performing its primary purpose of training personnel, a medical college treats the sick through its hospital, clinics and research. There is a dividend to our people in the incidental return in medical care which may well exceed the cost of the training program.

It is my sincere hope that this new hospital will provide tangible results in more and improved medical services within our State.

To that end we today dedicate this hospital and its facilities, and ask the staff members who will operate it to rededicate themselves to the service of their fellow man. There is no more honorable goal.

In the language of Dr. Robert Wilson, dean of this college a generation ago, our watchword might well be:

"A glorious past is a great inheritance, but its greatest glory is the projection of its life into an ever-progressing and forward-reaching future."

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EMERGENCY CONDITIONS OF THE NEWBORN INFANT

McLemore Birdsong, M. D.*
Associate Professor of Pediatrics
University of Virginia, School of Medicine

An editorial in the February 7, 1953 issue of the J. A. M. A. has noted that there has been a remarkable decrease in the death rate during the first year of life in the past 25 years but that the number of infants dying within the first 24 hours has decreased but little. It has been emphasized that since 1945 an infants chance of dying is greater during the first 24 hours than at anytime between the 2nd and the 12th month. This is true with even the much higher incidence of hospital deliveries.

The first slide shows the classical chart of the mortality rate over the past 25 years. It will be noted that great improvement is seen in groups of infants down to the group under one month of age. While the chart does show improvement it is much less so than the others.

The next slide shows the causes of the deaths under one month. Prematurity by far leads the list. Congenital conditions incompatible with life are also prominent causes. Congenital conditions which are correctable are also noted. Diarrheal diseases and infections are present but have been greatly reduced in recent years. Diseases involving the lungs are very conspicuous. While many of the conditions do not lend themselves to easy improvement, many others, if diagnosed in time and handled correctly, can be cured, thus reducing our relative high mortality in this age group.

The obstetrician has made great strides in the prevention of "bad babies" at birth by his constant urging of careful prenatal care. Many infants' lives are so saved as well as their mothers'. Complications of pregnancy and labor such as toxemia, hydramnios, aspiration, bleeding, asphyxia, trauma, etc. should alert the physician to be careful not to overlook any minor signs or symptoms in the infant as early correct diagnostic studies may be lifesaving. Unfortunately, many infants have correctable conditions that are undiagnosed until the infant's condition will not allow surgery or other forms of therapy necessary for recovery.

Since prematurity is such a large factor in the high mortality in early life, no discussion would be correct unless the problems of the care of the premature infant were included. I will try to do this by presenting what we consider to be the principles of premature care.

The first of these principles is the prevention of infection. The obstetrician can be of great help by furnishing any history of intrapartum infection. If there is a possibility of the infant being infected before or during birth, proper therapy can be started immediately.

Isolation is very important and a must in premature care. The premature nursery should be so placed in a hospital that no hospital traffic passes around it. Visitors should be carefully isolated from the infants. Only medical personnel absolutely necessary for care of the infants should go into the nursery. Specially trained nurses are usually all that is necessary for care except for the occasional examination by the physician. Infants with infection should be isolated from the well babies. Infants suspected of infection should be placed in a "suspicious nursery" isolated from both the sick and well babies. Individual aseptic technique should be practiced throughout the premature setup. It has been our practice to use prophylactic penicillin in all of our prematures under 3½ pounds, starting at about one week of age and continued for about three weeks. It is our opinion that this has decreased the incidence of various infections in our premature nursery.

The second principle is that of regulation of body temperature. As is well known, there is

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a difference of opinion concerning this point. Years ago, Dr. Kenneth Blackfan, professor and chief of pediatrics at the Children's and Infant's Hospital of Boston and Harvard Medical School, demonstrated that the maintainence of a temperature of 98° was not necessary but that it was probably advantageous to allow the infant to seek his own body temperature. This would tend to slow body metabolism and reduced coloric requirements and that a much more stable temperature was maintained. I had the good fortune to work under Dr. Blackfan and my training there as well as my experience since has convinced me that this method is safe and satisfactory. I have also had experience with an excellent medical center that maintained body temperature at very close to the so-called normal temperature of 98.6. The results of both institutions were excellent, but temperatures were certainly more regular with the Blackfan method and to keep temperatures at so-called normal required many incubators with frequent checking of the infants as well as the incubators. This tends to disturb the babies and I strongly feel the less the infants are disturbed, the better they will do. Regardless of the method used, the important thing is not to have wide variation in the body temperature. Marked drop or rise in temperature is frequently the first sign of illness in the premature. The regulation of body temperature is accomplished by various types of incubators, air-conditioned nurseries, various types of clothes and hot water bottles.

The third principle is the presence of a high humidity around the infants. The prematures need for water is proportionately greater than is the newborn. He loses large amounts of water by the skin, kidneys, and lungs. High humidity will reduce greatly the water loss by the lungs and can be most helpful in preventing drying and crusting of the secretion found so frequently in the bronchi of the prematures. High humidity is accomplished by almost all of the incubators now available and most modern nurseries have humidity controls on their air-conditioning units. Various vaporizers are available for less elaborate setups.

The fourth principle is nutrition. The time of the administration of the first food or fluid by mouth is important. In recent years, we have refrained from starting anything by mouth on our premature infants until their edema, seen so frequently on the hands and feet, has disappeared and until the infant shows signs of hunger. The signs of hunger are usually crying and chewing on fingers or vigorously sucking. Obviously, this can not be relied upon in the extremely small infants. By following such a routine we have had a marked decrease in vomiting and therefore aspiration of formulas. The incidence of aspiration pneumonia has been greatly reduced.

It is of equal importance to start with very small amounts of formula and gradually increase as the infant demands it. We are not too concerned over our infants getting 60-70 calories per pound of body weight as we were several years ago. The selection of food in our opinion is not too important. Breast milk is certainly an excellent food for prematures, but unfortunately, we do not have any real source of breast milk readily available. Consequently our experience, except with the unusual situation, had not been wide with breast milk as our chief source of food. We have been reasonably successful with most of the accepted formulas and have tried many. However, we seem to always come back to the routine lactic acid milk formula. In the small infants we have seen none more universally satisfactory but we do not think the other types of feeding are necessarily inferior. The methods of feeding will depend on the size and vigorousness of the premature. With the very small and weak baby we have found the indwelling nasal catheter of plastic material very satisfactory. This allows feeding of the infant at frequent intervals with least possible disturbances. Gavage feedings are used if occasional rest is necessary from nursing the bottle. The Breck feeder, eye dropper with a rubber tip and, of course, the usual bottle feedings are all used as indicated. Our small infants are occasionally given subcutaneous or intravenous fluids if their individual needs require it.

We should be extremely careful with electrolytes; large quantities of sodium, chlorides and potassium should not be used. A

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small quantity is all right, but the requirements for the small infants for these electrolytes are not great. Glucose in water or in diluted electrolyte fluid can be used.

The fifth principle is oxygenation. The most important step in getting oxygen to the premature or to any infant is to clear the air passages. The most important individual in accomplishing this is our obstetrician or the person delivering the infant. Here is the best opportunity to get the air passages clear. At the time of birth, as the head comes over the perineum, the chest wall is being compressed by the birth canal and this is the time that careful, not vigorous, suction should be made of the nasopharynx and throat. As the infants are born and take their first gasp of air, all of this material can be pulled back into the lungs which can lead sometimes to disastrous results. Another very important thing is the question of analgesia or anesthesia at this time. Premature mortality is greatly influenced by respiratory conditions. Consequently, if we have a premature given to us in good condition by the obstetrician or general practitioner or whoever delivers the infant, they are the important part in reducing this mortality. The minimum of sedation should be used in order to prevent an infant's being at all depressed at the time of birth. Suction of the posterior pharynx can be done by the pediatricians. We routinely take our premature infants and put them in a head-down position. Occasionally, catheterization of the trachea is necessary and on occasions, bronchoscopy has been used. The last two are used infrequently as the first two methods seem to work very nicely.

The second point here is the oxygen. As you know, there has been a rash of papers concerning the role of oxygen in the development of retro-lental fibroplasia. Whether this is true or not, I do not know and at the present time, in our premature nursery we give a high oxygen concentration until respiration is established. That may be one minute, ten minutes, thirty minutes, or it may be several hours. At this time, we begin to lower our oxygen concentration until the minimum point at which the child can stay comfortable. That can be six liters, it can be ten liters, it can be one liter, or, of course, it can be none at all. Recently the use of oxygen at 40% concentration has been used and it seems to satisfy the need. It is certainly important to use the lowest amount of oxygen you can use, and another thing we think is important is not to take these children from a high oxygen concentration out into a normal atmospheric oxygen suddenly. Gradually take them out over a period of 24 hours or more. We think this may be helpful.

The sixth principle is supportive therapy. We of course use vitamin K routinely in our mothers and the infants are given vitamin K as they come to our nursery. Blood and plasma transfusions are occasionally necessary, but are not routine. Iron can be given orally or intravenously to try to combat the anemia of prematurity. Because iron does not always sit very well in the stomach of the premature infant, the use of intravenous iron has been a great help in handling this problem.

Using such a routine in the past few years we have been gratified with our findings in comparing our figures with our previous ones. Our mortality rate in the infants under 1,000 grams was 95.7%; now that is high. If we had raised one more premature infant under 1,000 grams, it would be an outstanding figure because these figures comprised two infants under 1,000 grams that we have raised in the past three years. We have many of these infants, but not many of them live. Of course, when I say under 1,000 grams I mean any viable child who breathes and is sent to our nursery and is regarded as a live birth. That 95.7% does not mean very much, but from there down we are very proud of our figures. From 1,000 to 1,500 grams our mortality rate in this group is 41.55%. From 1,500 to 2,000 grams, our mortality was only 7.88%. From 2,000 to 2,500 grams, our mortality was 2.6%, giving us an over-all mortality of 14.2% and a mortality under 1,000 grams of 10.16%. These figures we are proud of; they compare favorably with any institution. We do not take credit for this mortality rate ourselves, for we feel that a large amount of credit is due our obstetricians who have given us good babies with which to work.

Conditions involving the lungs and dia-

phragm are usually recognized easily clinically. These signs and symptoms consist chiefly of cyanosis, respiratory irregularity, thoracic respiratory effort, gross inequality of respiratory excursions, thoracic percussion dullness and signs of mediastinal shift. It is our contention that any infant showing these signs or symptoms should be x-rayed immediately and in our experience films have given most helpful information.

This slide shows a premature infant who weighed 2,400 grams when admitted to our institution at eight hours of age with cyanosis and dyspnea. It was relieved by oxygen, but cyanosis returned promptly whenever oxygen was discontinued. Physical examination showed difficult respiration; there was dullness to percussion over the left side of the chest and poor aeration to auscultation. The x-ray shows the entire left lung collapsed, with the heart and mediastinum drawn to the left. This child was given the usual treatment for atelectasis, which consisted of stimulation; he was turned, he was sucked thoroughly without any improvement. We worked with him for about two days in such a regime without any improvement and he was going downhill. The EENT Department was consulted and it was decided to use the bronchoscope on this patient. No obstruction was seen in his trachea at all and a catheter was passed in his left main-stem bronchus and it was sucked for about 30 seconds with a fair amount of mucoid material obtained. Immediately after the procedure, the child improved and in 24 hours x-ray of his chest revealed a clear lung. Twenty-four hours later that left lung was practically clear. This child went on to make an uneventful recovery. We feel that bronchoscopy was lifesaving as the child was certainly dying at the time of this procedure.

This slide shows another case of atelectasis. This was a premature infant weighing 1,870 grams having marked cyanosis and dyspnea at birth. This was relieved somewhat with oxygen, but whenever oxygen was discontinued the cyanosis returned. The physical examination revealed a small infant. Positive findings were dullness to percussion over the left chest and absence of breath sounds over the same area. There was a definite abnormality of the left ear which I think is extremely important. We should always remember whenever a newborn infant, premature or not, has a congenital anomaly that you can see, you'd better look for others. Congenital anomalies that you can see frequently have company and it behooves the person to look carefully for other difficulties. X-ray as you see here reveals the left chest to be opaque with the heart and mediastinum pulled over to the left. There were also in this x-ray abnormalities of the ribs which you see; there are some bifid ribs and in the upper thoracic area there are some hemi-vertebrae present. We watched this infant for a few days and again called in our EENT Department and a bronchoscopy was done. They found a very narrow left main-stem bronchus. Another bronchoscopy was done later with iodized oil being used and it was seen that the left bronchus ended in a blind pouch. Diagnosis of congenital absence of the left main-stem bronchus was made. This child, after several weeks in oxygen, improved.

This is the x-ray of the child at 11 years of age; you will notice he has scoliosis, and there is some herniation of his right lung through the mediastinum, but this child has grown well. Except for becoming short of breath on violent exercise, he lives a pretty normal life. He can ride a bicycle or play touch football for a couple of minutes, but then he has to stop and rest for a while, but on the whole he has done very well.

The next condition I would like to talk about is a disease which we have seen in the literature for the last four or five years known as pulmonary hyaline membrane disease.

This condition usually occurs in premature infants or cesarean section infants and always should be considered when we have either of these conditions. The child should be watched very carefully. The cause of this condition is quite controversial and to go into that would be a program in itself. I think it is better to say we don't know definitely the cause of the disease. I would also like to state that this is a pathological diagnosis. You can't be sure you have pulmonary hyaline membrane disease unless a postmortem examination is done

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and you see the pulmonary hyaline disease in the lungs. However, the cases are so similar clinically, that we hazard a guess that the disease occurs in patients that recover. The characteristic course of this disease is important and anyone who had had anything to do with newborn infants I am sure has seen this disease. These are the infants that are premature or "sections." The doctor does his job, everything seems to be fine, the baby looks well, the doctor feels happy, so he goes back to his office or home and anywhere from four to twelve hours later he is called back to see the infant because it is having marked respiratory distress. There was no difficulty at the time of birth, which is extremely important in the clinical diagnosis, but it gets into difficulty. Why is this? The baby seemed to be fine and now he is going all to pieces. This progressively gets worse. The child first begins to breathe a little faster, then you have extra-thoracic effort with the abdominal muscles being pulled in rather violently with the breathing, the sternum tends to drop in with each breath, the suprasternal notch caves in with inspiration. Aeration is not good. Physical examination done at this time usually reveals nothing. Air is going through the lungs although it is not good. We usually don't get any rales; we don't get any dullness. X-ray examination of these infants at this time do not show atelectasis. This is an x-ray taken at 24 hours of age. There is not good aeration close to the hilus area, but if anything, there is emphysema present rather than atelectasis. The child progressively gets worse and can die at almost any time. However, in the greatest majority of cases, if we can keep these babies alive for four days, they will recover.

The next slide shows an x-ray taken of the same child at four days of age and there is a marked difference in this child's lungs. It doesn't look like he can possibly live with no more lung field than he has. Actually, when this x-ray was taken, this child was beginning to improve. His respirations were becoming less labored and he was looking somewhat better. The next picture was taken on the fifth day of life, 24 hours after the previous plate, and you will see what has happened here. We feel that this is a case of hyaline membrane disease that recovered.

I think it is quite important to make a clinical diagnosis of this condition, because these patients are handled differently from so-called atelectasis. If you have this clinical picture, these patients should be left alone. Leave them alone as much as possible. In a recent conversation with Dr. C. H. Mauzy of Bowman Gray Medical School, he stated that he liked the Bloxsom Airlock Resuscitator because it kept pediatricians from bothering the baby. At least in this disease, leaving the infant alone is important. We use oxygen and moisture in incubators; we do not use alevaire but we use plain water. We put the infants in a head-down position; they are given prophylactic antibiotics to prevent infection and are left entirely alone. As they begin to improve, we will start feeding these infants. Since we have started this routine, we have certainly cut down our mortality. Another thing that we do routinely in our nursery is to take all premature and all sections at the time of birth, pass a tube into the stomach and evacuate the stomach contents. Whether this is of any value I do not know, but Gellis in an article in the last 18 months has advocated this procedure and we do it.

The next slide was of an interesting infant. This was a full-term infant, born without difficulty; however, there were immediately after birth cyanosis and respiratory difficulty noted. At 24 hours of age, he was x-rayed. The x-ray was said to show atelectasis of the left lung. The child remained cyanotic and was referred to us on his fifth day of life. He was brought in from an ambulance from well down in North Carolina; how it got to the University of Virginia Hospital I don't know, but it got there. It was moribund, gray, cyanotic and had extremely poor respiratory efforts. There were practically no breath sounds at all in the right side. You will remember I told you that his x-ray taken at 24 hours of age was said to show atelectasis in the left lung. He came to us with practically no breath sounds on the right side. He was critically ill, he was immediately x-rayed and the x-ray showed a tension pneumo-thorax of the right with herniation of

the air through the mediastinum. You can see in the upper right x-ray the air pushing through the mediastinum. As soon as these x-rays were done, we put a needle in the right side of this child's chest and relieved his tension with immediate relief of his symptoms. As soon as this was relieved, the surgeons came and put a closed drainage in this child's chest for 24 hours and he made an uneventful recovery. This child is most gratifying to us because he was practically dead when he arrived.

The next patient was a supposedly normal baby at birth. Cyanosis and difficulty in swallowing was noted for 24 hours after discharge from his local hospital. He continued to have difficulty and ran a little fever and in the third week was seen by his family physician who on a physical examination found signs of dullness in the right side of the chest and did a thorancentesis and obtained a yellow purulent material. He was then immediately referred to our hospital for therapy. On x-ray, this child showed signs described — he was x-rayed and we thought that he had an encapsulated pneumothorax with atelectasis of the right lung and marked shift of the mediastinum to the left. Closed drainage was started on this child. However, this child still remained sick, and did not do well, so after about 24 hours, because he did not respond, it was decided that there was something else going on in this child and we carefully looked at the x-rays again and you can see cystic areas in the lung. A thoracotomy was performed, lobectomy was accomplished and the pathological study showed numerous cysts, marked bronchiectasis, all of which were rather badly infected. This child, after his procedure, made a very satisfactory recovery.

The next case represents a disease that is not uncommon and a physical examination will usually make you suspect such a disease. This child had a pre-eclamptic mother, it was born without difficulty, it was somewhat sluggish, slow to cry, stayed somewhat cyanotic. The physical examination at the time of birth was not revealing; however, the child did not improve and about six hours later the child was re-examined at which time the examination did reveal something and I would like to say that on this particular child the examination was done by the same resident and I'm sure that he was accurate in his findings. At his second physical examination, it was noticed that the infant was in respiratory distress, there was dullness noted in both lungs to percussion. There was an absence of breath sounds on the left, and one of the most important things found was that the heart-beat was about 3 cm. to the right of the sternum. Any child in respiratory distress in which you hear the heart-beat to the right makes you consider a diaphragmatic hernia. The x-ray examination is perfectly obvious. This child became worse because in his first examination he had very little air in his intestinal tract. Later, all of this ballooned up and caused more compression of his lungs: and then his symptoms became worse. Vomiting is also frequently associated with this condition. X-ray is pretty diagnostic, but on occasions you can be somewhat fooled by it. It may be necessary to give the infant a little Lipiodol and watch it go through the intestinal tract to see it come up in the chest. This child underwent surgery and all of the intestinal viscera, except the descending colon, were in the chest. The surgeon was able to pull down the viscera very nicely and made a primary repair with an uneventful recovery. It is important to make diagnosis early in these patients simply because vomiting is so frequently associated with this and aspiration and lung disease will cause death.

Drooling, vomiting, strangling are very important symptoms in the newborn infant. All nursery nurses should be taught to immediately notify the physician if such occurs. These are early signs of esophageal atresia and early diagnosis is essential for careful care. The diagnosis is simple. Surgical technique has advanced to the stage now that if a patient is not drowned in his own secretion, or does not have pneumonia his chance for recovery is excellent.

This is a classical case of a tracheo-esophageal fistula showing a blind upper pouch and also you will notice that there is plenty of air in the abdomen which means that you have a connection of the lower segment with the trachea. This is a classical finding. It is so simple to make this diagnosis if you are

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notified and will simply pass a little rubber catheter into the esophagus. If you run into obstruction your diagnosis is made. It is confirmed by x-ray; by putting a small amount of Lipiodol in the esophagus. Use small amounts of Lipiodol to prevent a spill over of the oil in the lungs. You should always remove that Lipiodol when the examination is completed.

The next slide is another example of atresia of the esophagus in which too much Lipidol was used and I'd like to show you the bronchogram which we obtained. This is not good technique. This is a rare type of esophageal atresia in which there is a blind upper pouch as well as a blind lower pouch. You will notice that there is no gas in the intestinal tract. These cases can and should be diagnosed early. We have taught our nurses to be on the alert for this condition. In the past four years, we have not had any infant with a tracheo-esophageal fistula who has not been on the operating table by 24 hours of age.

The finding of abdominal mass, other than the liver or spleen is an emergency that requires prompt diagnostic test. Flat plates of the abdomen may be helpful. Intravenous pyelograms will quickly locate or eliminate the kidney as a cause. Barium study of the upper and lower gastrointestinal tract is sometimes necessary to aid diagnosis and proper treatment. Hydronephrosis, tumors, cystic kidneys, cysts are the most common cause of abdominal masses in the newborn.

The next slide is of an infant whose examination at the time of birth revealed a mass in the left flank. The urine showed 24 WBC with a trace of albumin, the urea was 21. Flat plate was negative. Intravenous pyelogram revealed a non-functioning left kidney. This was a small male and the urologists did not feel that they wanted to try to do a retrograde cystoscopy on this infant so he was taken down to the urology operating room. While I held the infant in a sitting position the urologist got the mass in his hand, stuck a needle into the mass, and we got what proved to be urine so we injected a little dye.

This was of course a hydronephrotic kidney. When the diagnosis was made, a left nephrectomy was performed. The amazing thing about this infant was that it was a breast-fed baby who missed its ten o'clock feeding because he was on the operating table. He went back to breast at 2 o'clock in the afternoon and did not gain weight on this particular day. However, except for that, he was discharged on the 11th hospital day in excellent condition.

The next slide is a newborn infant who was examined at the time of birth and a hard firm mass was found in the right side. A flat film of the infant was obtained and you can see the mass on x-ray. The urine was entirely clear, his urea was normal. We tried intravenous pyelograms on this infant and it may be difficult to see, but in the lower pole there is dye which is pushed downward and forward and an elongation of the kidney is shown. The differential diagnosis, because the x-ray was not too revealing, was between a neuroblastoma and a congenital Wilms' tumor. X-rays of all the long bones were negative. Our urologists felt that this mass was so large that they were afraid to operate on it in its present stage, so the infant was given x-ray therapy for 13 days and the mass reduced to one-half its original size. Operation and nephrectomy were performed and the pathology of this tumor proved that it was a Wilms' tumor. The child is now in the second grade in school. She has an annual examination each year, and when seen this past September, was in excellent condition. We feel that we have gotten a cure.

Vomiting is a common symptom in infancy, but it should not be passed over lightly. The type of vomiting, the presence or absence of bile in the vomitus, the presence or absence of distention, the general appearance of the infant in regard to being in pain, the passage or the lack of passage of stools, the character of the stools, are all important findings in determining the cause of vomiting. Physical examination, x-ray examination, and microscopic examination of stained stool smears can be very helpful in making a diagnosis.

This slide shows a patient who presents a classical picture of intestinal obstruction. The next slide is the upright plate which is perfectly classical, showing no air or gas in the lower bowel. Any time this picture is seen, we call our surgeons and usually something is done in

a very short time. In this child, the only thing unusual is that instead of having one obstruction, he had two. However, he managed to survive after about 24 days in the hospital.

The next condition is in a patient who was referred to us from outside after a difficult delivery and it was thought that he had an intracranial hemorrhage. When he came in he was very ill. He had been vomiting a material which was black and dark greenish in color. He was quite distended and rales were present in his lungs. We thought that he had an intestinal obstruction so a flat plate of his abdomen was done which showed features from which the diagnosis can be made on x-ray. You will see the calcium deposits throughout the abdomen. This is a classical x-ray picture of a congenital meconium peritonitis. It is always associated with obstruction and perforation. The meconium is spilled into the peritoneum and will calcify. This child of course underwent surgery and he had a severe chronic peritonitis of a sterile type. An atresia of the jejuneum with many thick adhesions throughout the peritoneum was found. Surgical correction was accomplished with recovery.

The next slide shows the x-ray findings seen in a case of malrotation of the gut. This has not been an uncommon disease condition in our institution. This condition should be considered when there are signs of intermittent intestinal obstruction. The finding of bile in vomitus as well as the passage of stools containing bile with the signs of intestinal obstruction should alert the physician to the possible diagnosis of malrotation of the gut. Volvulus may or may not be an associated finding. If possible, diagnosis should be made before operation as a very confusing picture may face the surgeon if he does not suspect or recognize the situation at operation. Barium enema or Lipiodol enema may be quite helpful in arriving at a correct diagnosis by locating the cecum. As you know, in malrotation of the gut the cecum has not completed its normal rotation to the right lower part of the abdomen and may be found in any position. It is frequently located in the left or right upper abdomen. This child was operated upon successfully and is now in an excellent state of health.

The failure to pass meconium within 24 hours of life is a serious symptom. Meconium ileus or atresia or stenosis or the lower gastrointestinal tract should be considered. Unfortunately, this symptom is often overlooked and when it is the patient can become ill before diagnosis is made. Careful rectal examination should be done routinely on all newborn infants. If there is failure to recover meconium or finding of atresia of the lower part of the rectum or the anus, surgical consultation should be requested. The slide shows an x-ray taken with the infant in an inverted position with a metal probe on the anus. This is helpful in finding the distance from the obstructed anus and the patent gut. In this patient the gut can be seen almost touching the rectum, therefore the surgeon operated from below and easily found the gut that could be pulled down for a good anastomosis. If this distance is great, it would require an abdominal operation and later plastic stages to try to establish a patent anus or rectum.

In conclusion I would like to make a plea for all physicians who have the responsibility for the care of newborn infants to do careful physical examinations on these patients. Be careful to notice minor symptoms or signs. If this is done, early signs of potentially dangerous conditions can be found and if proper consultation and examinations are done the diagnosis can be made. This will lead to treatment before the infant is in critical condition.

Medical and surgical treatment has advanced to the point that many deaths are avoidable if therapy can be started in time and by these means the high death rate in the neonatal period can be curtailed.

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THE OPERATIVE TREATMENT OF PECTUS EXCAVATUM

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A considerable number of deformities of the chest wall challenge the skill and the ingenuity of the surgeon. The sternum may be entirely bifid with or without ventral displacement of the heart. This is a serious anomaly, relatively readily repaired early in infancy, and only with difficulty or not at all, subsequently. We have had the opportunity to treat a number of children with absence of ribs in various portions of the thoracic cage. These have been repaired by varying combinations of osteoplastic procedures on the ribs and fascial grafts or reinforcements. Pigeon breast (pectus carinatum) is another striking deformity with its forward thrust of the sternum and the parallel depressions on either side of it. However, the largest experience to date with repair of the deformities of the bony thorax, has to do with the condition known as pectus excavatum or funnel chest, called by earlier writers Trichterbrust.

Pectus excavatum is a congenital anomaly in which the body of the sternum is depressed to form a concavity which may reach to the vertebral bodies, or, passing to one side, into the paravertebral gutter. The lower costal cartilages on either side bend back toward the dorsally displaced sternum giving breadth to the concavity, the depth of which is usually maximal just above the xiphi-sternal junction. There is, therefore, a concavity from side to side and from above downwards. The deformity is commonly noted soon after birth and the feature of greatest importance is the tendency toward progression. The degree and rate of progression are variable and inconstant. In most of our patients the deformity has been noted at birth, but in a few, competent observers failed to observe the deformity until the infant was several weeks or months old. In the undressed patient, the concavity is conspicuous and unsightly and a source of embarrassment to young individuals of either sex. The deformity of the rib cage and the spine in the more severe instances is quite plain, even when the patient is clothed. These patients usually have a thorax with decreased anteroposterior diameter, a moderate dorsal kyphos, and carry their heads thrust forward. Paradoxical inward motion of the sternum with inspiratory movement is a conspicuous feature of the deformity in infants and children, until with increasing years, the chest wall becomes rigid. This paradoxical inspiratory motion of the sternum may be seen to an astonishing degree in infants with the deformity. There is commonly a prominent protrusion of the abdomen on inspiration. The etiology of the deformity is not well established. It is commonly ascribed to a shortening or contracture of the central tendon of the diaphragm. That the deformity is increased by the pull of the diaphragm, is beyond question, but it may be observed that the maximal depth of the deformity is frequently some distance above the level of diaphragmatic attachment. Furthermore the appearance of the deformity at birth in these patients would leave one to assume that some mechanism other than diaphragmatic pull was responsible. Rickets and scurvy are certainly not involved. The costal cartilages are obviously increased in length in following an indirect course to the sternal border, and it has been suggested that the increase in length of the costal cartilages may be primary rather than secondary.

In some instances, the heart is compressed between the spine and the sternum, but more often, the depression of the sternum displaces the heart to the left even in the less severe cases. In the more severe deformities, the heart is displaced far to the left and rotated posteriorly. Pushed out in the left hemithorax, in a patient with a flat, thin chest, the heart gives the impression of being imprisoned in the

flattened chest between the anterior and posterior parietes and, in fact, it may be so imprisoned. Such a degree of deformity does not often develop before adolescence, but it is not possible to predict which infant with pectus excavatum will go on to develop a severe deformity and which will not. The physiological consequences of this deformity appear to have been neglected. While severe cardiac embarrassment is rare, it does occur. We have operated upon one patient who had had two attacks of cardiac failure and presented in one of these attacks with auricular fibrillation. After initial treatment with digitalis and quinidine, his thoracic deformity was corrected. He has returned to full activity as an inter-urban bus driver. He has a regular rhythm and takes no medication. Another patient had been treated for a year because of a diagnosis of hyperthyroidism based on a persistant tachycardia, which receded after correction of her deep funnel chest. There are several reports of patients who have died with dyspnea and cardiac failure, in whom at autopsy no abnormality could be found except a severe pectus excavatum. However, this degree of cardiac embarrassment is uncommon. Infants and small children are usually totally asymptomatic as far as their hearts are concerned. However, we are frequently told by their parents that after operation the children are more energetic and vigorous than they had ever been before. Older children and young adults will practically all have some demonstrable degree of limitation of exercise tolerance. It may be no more than that of the college student who could play one set of tennis but not two, or of the high school boy who could race one lap around the track but no more, or of the Boy Scout who could go on hikes with his comrades, but invariably fell behind when the going was uphill. These symptomatic findings can be correlated to some degree with clinical investigation. Studies with the electrocardiogram with multiple precordial leads and, more recently, particularly with the vectorcardiogram, show evidences of cardiac irritability, arrhythmias, and varying degrees, often quite marked, of rotation. These findings are usually reversed by operation. A good many of these patients have been noted to have systolic "functional" murmurs which may or may not disappear after operation. An unexpected finding in the infants operated upon for pectus excavatum, was the report by the mothers that the infants fed better than before. In only one or two infants have we had before operation a definite story of an unusual degree of regurgitation or of difficulty in swallowing, but in a good many infants, we have been told after operation that the child swallowed with such ease, that the mother was aware for the first time that there must have been some difficulty in swallowing before operation.

The older children are frequently conscious of their deformities, and especially in the case of boys, suffer a good deal of teasing from their playmates. It is in these older children, too, that there often occurs after operative correction the sudden discovery of increased exercise tolerance, although it had not been appreciated before that any limitation of exercise tolerance existed.

INDICATIONS FOR OPERATION

It is to be emphasized that infants and small children have few, if any, symptoms even when the deformity is severe. However, it is our feeling that operation should be undertaken in all fairly marked instances of pectus excavatum in infancy and childhood, in the absence of other and overriding defects or disabilities, such as cardiac anomalies or multiple skeletal anomalies of the type seen in Marfan's disease. Funnel chest is seen with considerable frequency among children with congenital cardiac defects or multiple skeletal defects. Operation is undertaken to correct the existing deformity and to prevent its progress. The younger the patient at the time of correction, the more favorable are his chances of attaining a normal thoracic contour with subsequent growth of the rib cage. If the deformity is severe, or if a competent pediatrician has observed it to progress, operation is undertaken at any age. Our youngest patient was three months old at the time of operation. Operation is therefore undertaken for physiologic, orthopedic, and cosmetic reasons. If dyspnea, exercise intolerance, or cardiac ar-

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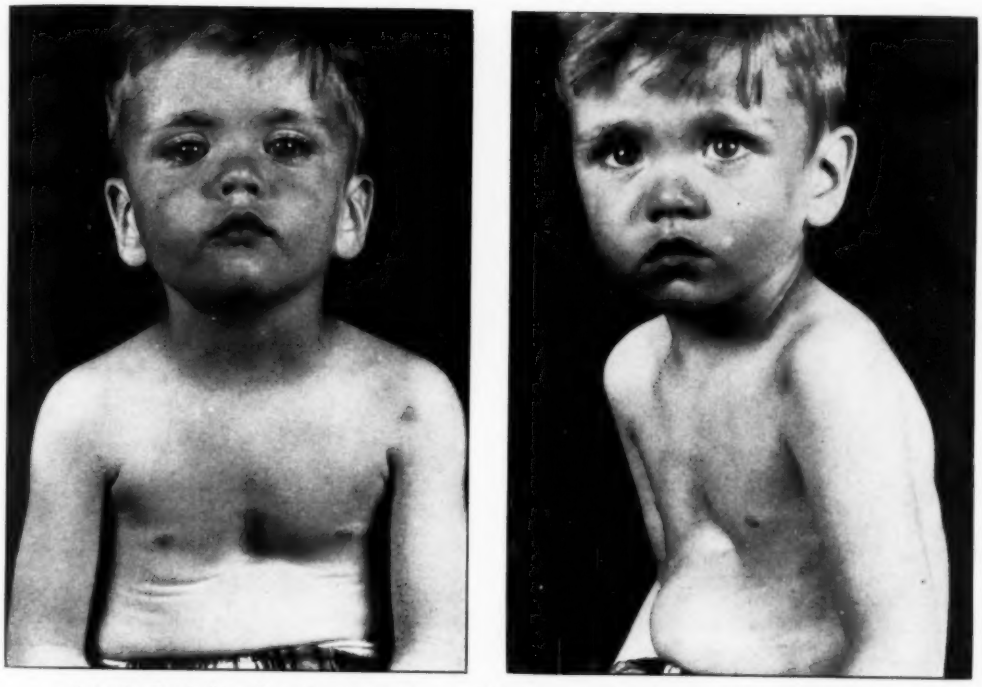
rhythmias are present, operation is strongly indicated. However, most children have no such symptoms and operation is generally advised in their absence. In children with pronounced defects, operation should be undertaken before there is any marked general thoracic deformity and before marked physiological disturbances occur. One can not predict which children will ultimately suffer most if not operated upon. On the other hand, one may say that a less formidable procedure in infancy will probably insure normal development, whereas more extensive operation some years later may produce only a partial correction of the deformity. We do, of course, see a good many children with trifling sternal depressions whom we dismiss as not requiring operation.

The antero-posterior flattening of the chest and the kyphosis may improve or disappear if operation is performed early enough. The younger the patient is, the simpler and smaller the procedure and the better the results that may be expected. Corrective exercises can not be expected to achieve much for an actual skeletal deformity such as this.

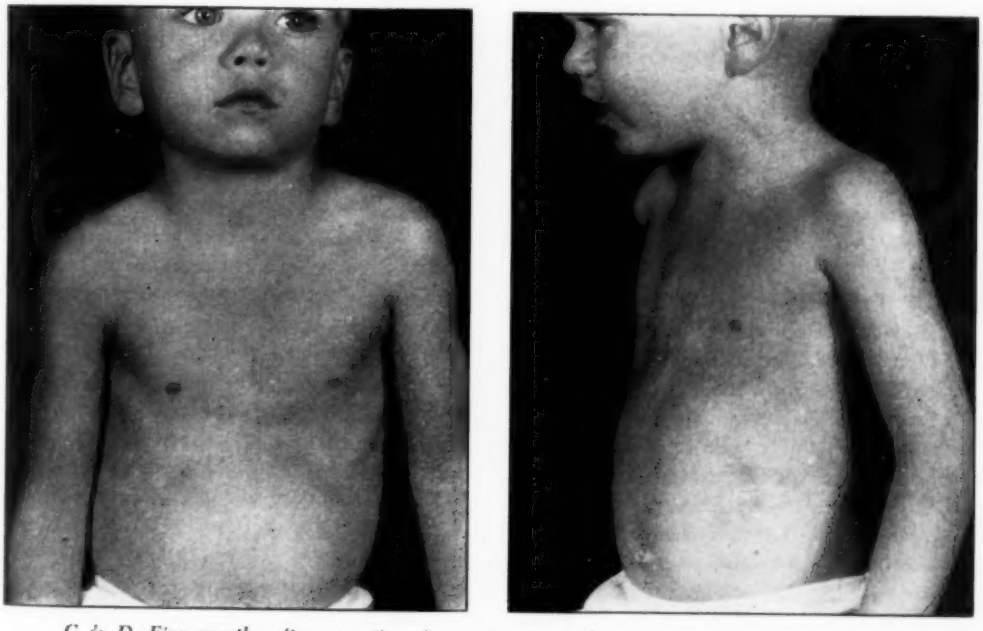
The deformity itself is the source of concern to children and parents and the basis for teasing by playmates. A sunken chest with the clothes worn by both sexes today, can scarcely be hidden, particularly in the summer time. The extent to which a patient and his family have been disturbed, has usually been fully appreciated only after operation. Parents are apparently loathe to admit to wanting an operation of this character for what they construe as cosmetic reasons, but the correction of the defect seems to permit the patient and family alike to discuss freely what had previously been minimized by a protective reticence.

TECHNIQUE OF OPERATION

The operation as performed at present differs only in a few details from that reported in 1949. We aim to prevent progression of the deformity and to correct the deformity already existing. The operation is designed to remove the distorted cartilages, to bring the sternum into its proper position, and to free it from all structures which might tend to maintain the deformity. Under intratracheal anesthesia, a midline incision is made from manubrium to epigastrium, down to the sternal periostium and the linea alba. Pectoral muscles are stripped back in a sheet on either side without any preliminary elevation of skin flaps. With proper instruments, even in the smallest infants, subperichondrial resection of the cartilages can be readily effected and we feel that with the perichondrium left behind, the chest wall becomes firm much sooner, usually within three weeks. As many cartilages as are deformed are removed for the full length of their involved segments, usually four or five, often out to the costochondral junction. The xiphisternal joint is divided. We are seldom able to find any structure of significance to call a substernal ligament. The intercostal bundles are divided from the sternum, isolating the sternum entirely as a peninsula, attached only above to the manubrium. A transverse cuneiform osteotomy is performed at the cephalad limit of the sternal deformity cutting through only the anterior cortical lamella, and scraping out a little of the cancellous bone. The sternum is lifted forward, and bent back and forth until the posterior cortical lamella, its only attachment, is fractured, correcting the posterior displacement. In older children and in young adults, we usually cut a half centimeter slice out of the costal cartilage above the highest one resected. This permits us to perform the sternal osteotomy one interspace higher, thus achieving maximal correction. At the same time, it permits fixation of the sternum not only across the sternal osteotomy, but also across the two cartilage incisions. The sternum is maintained in the corrected position by mattress sutures of heavy silk placed across the osteotomy. We feel that silk is less likely to break than wire, and much less likely to cut through the bone. In addition, the sternal periosteum is carefully repaired with interrupted sutures of silk. In those patients in whom one more costal cartilage has been transected, a heavy silk suture is used to unite the cartilages. The intercostal bundles are occasionally tacked lightly to the under surface of the sternum, if this does not appear to exert any traction upon the sternum. The



A & B. Typical sunken chest, protuberant abdomen, forward thrust of head and rounded shoulders.



C & D. Five months after operation. Inconspicuous midline scar, normal thoracic contour, greatly improved posture.

FIGURE 1
R. McD. 3 years old

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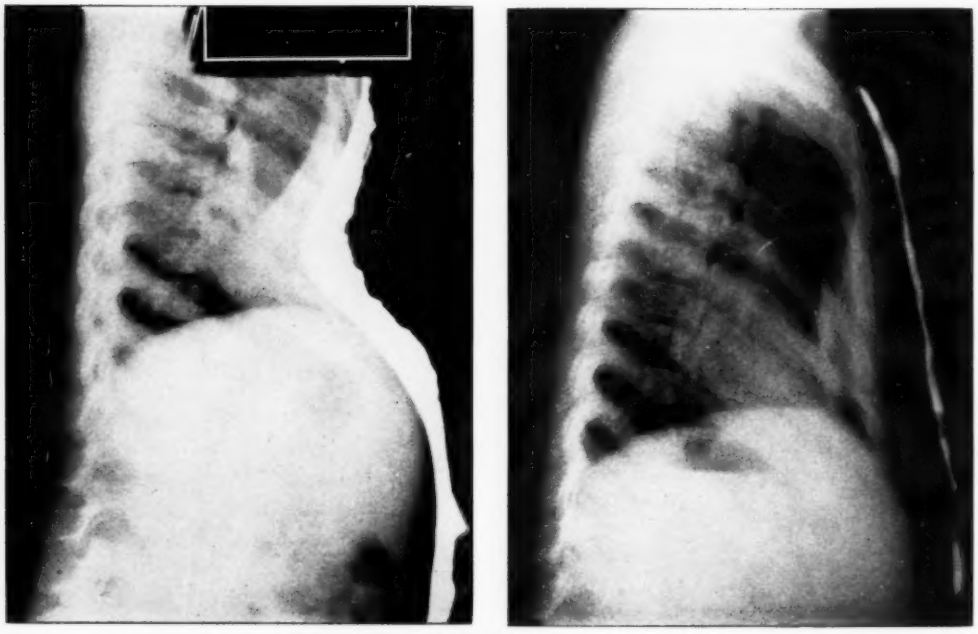

FIGURE II
P. S. 3½ years old

A. Preoperative roentgenogram with barium stripe on midline. There is marked posterior displacement of the sternum almost reaching the vertebral column, obscuring the shadow of the heart which has been displaced into the right chest.

B. Postoperative roengenogram. Ventral contour shows correction of indentation. The heart has moved into the space created for it.

xiphoid is left detached. The pectoral muscles are tacked back to the sternum in the midline. No external traction or fixation of any kind is employed, and we have not found any to be necessary.

POSTOPERATIVE CARE

Postoperative respiratory distress is uncommon. Most of the patients do not require oxygen and significant paradoxical respiration does not occur. One can always see an area of paradoxical motion which is actually in the epigastrium and involves the area between the detached xiphoid and the sternum. This motion disappears within two to three weeks. The patients may have tachycardia and fever for a day or two, but they are up and about on the second or third day. Fluid frequently collects between the skin flaps and requires a needle aspiration until it fails to re-form. If it is not aspirated with sufficient promptness, it may force its way out through the wound. No protective dressing or apparatus is employed and for the past year we have been dressing these wounds solely with an aerosol spray of translucent rubber cement-like material. The patients usually leave the hospital five to seven days after operation.

RESULTS

Our experience now comprises 47 operations performed on 40 children and 7 adults varying in age from three months to thirty-eight years. The operation is no more difficult in the infants than in the older children and is certainly much easier in both than in adults. The babies tolerate the procedure very well and it has therefore been our practice to ignore the factor of age, making the decision to operate in infants and children, whenever operation appears required for a deep or progressing deformity. There has been a single death,—

in the second child operated upon, who developed a massive and immediate wound infection. There has been no other serious complication. Entrance into the pleura is not a rare occurence, but is of little moment. The results have been satisfactory and sustained, both as regards the sternum and thoracic contour and as regards the general condition of the children. While the anterior portion of the thorax may often appear rather flat after operation, as opposed to the rounded normal chest, it is never sunken. In two children, one a boy of three, one a boy of fourteen, the depression is gone, the general result is good, and the adolescent notices considerable improvement in exercise tolerance, but the sternum is not solidly united and tends to slope downward and in. In both these instances, it was proposed to place a strut beneath the lower end of the sternum, such as is recommended by several authors. However, in both instances the parents have stated that they are far too well satisfied with the result to be interested in another operative procedure. It is regularly reported by the parents that the children eat better and play more vigorously. The adolescents and young adults remark upon increased exercise tolerance and freedom from fatigue, even when they had made no complaints in these respects before operation. Those patients with cardiac difficulties before operation have been relieved of these and in most instances the electrocardiographic and vectorcardiographic evidences of cardiac displacement and rotation have disappeared.

PROBLEMS OF PREPAID SICKNESS INSURANCE*

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The basic problems of prepaid sickness insurance arise from unnecessary and wasteful utilization of hospital facilities by insured persons. This statement applies to both Blue Cross and Blue Shield non-profit insurance plans and to commercial insurance carriers. Already over-utilization has forced costs of sickness insurance up so high that such insurance is out of reach of at least twenty-five per cent of American families. That is bad, but what is even worse is that, in spite of successive rate increases and some restrictions in benefits, most Blue Cross and some Blue Shield plans are experiencing financial difficulties. It is said that some commercial companies are compensating for losses from sickness insurance contracts by profits from life insurance coverage. These commercial companies are able to restrict their losses to a considerable extent by the device of providing only cash indemnities with definite limitations.

The basic and unique principle of Blue Cross is to insure against all necessary hospital costs of covered illnesses. In so far as it deviates from that principle, it approaches the type of coverage offered by commercial companies. Blue Shield attempts to provide similar service benefits to low and medium income groups, and in that way to take care of the doctor's entire bill. Perhaps, the fear of the *unpredictability* of the amount of the costs of illness is greater than the fear of illness expense itself. When a Blue Cross member knows that he, by simply presenting his identification card, can be admitted to a member hospital without making an advance payment and with no expectation of a bill for extras, he enjoys a marvelous peace of mind which has therapeutic value. There is no fear of embarrassment or of insolvency.

Blue Cross membership at first was offered only to employed groups, and the required percentage of enrollment of members of the group was consistently high. These two restrictive limitations were safeguards, keeping low the incidence of admission to the plans of

*Read by invitation before The Association of Surgeons of the Southern Railway System, Augusta, Ga., April 2, 1955.

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persons already sick and those destined to become sick. But they also restricted eligibility for membership, so that individuals employed in small groups and those not employed in a group, were denied the possibility of buying non-profit insurance giving service benefits.

By a method of trial and error, combined with writing into the membership agreement a provision for waiting periods before coverage of certain conditions, chiefly those present at the time of admission to membership, restrictions for eligibility for membership in Blue Cross have been reduced, so that now almost anyone, not already sick, and under sixty-five years of age, may join a Blue Cross plan.

Coincidental with this broadening of eligibility for Blue Cross membership, the spiral of increasing hospital costs began. There soon followed the building of many new hospitals. With all hospital charges covered by Blue Cross, it became both more convenient and cheaper to be sick in hospital than at home. It became also more worthwhile to join a plan in *contemplation* of operation or other illness, and to demand either that the doctor fake the history or to change doctors. Utilization began to climb and it is still climbing.

There have arisen several other factors tending to increase hospital utilization. Doctors, busy as they are, and more scientific in their approach to diagnosis, and more impatient for results, prefer hospital patients rather than home patients. They are inclined to advise hospitalization for minor illness. Furthermore, once the patient is in the hospital, it is so easy to order x-ray examinations, repeated laboratory examinations, EKGs, BMRs, etc., that such examinations are ordered frequently without very well thought through indications. Furthermore, because of half-knowledge gotten from reading and parlor conversation, patients are asking for these tests—especially when they have insurance. A head cold often calls for a chest film and probably a film of the accessory nasal sinuses; pain or discomfort in the chest or upper abdomen frequently calls for an EKG an upper GI series, and gallbladder visualization; backache, either recent or of long standing, calls for a film of the spine; not infrequently, headache is studied chiefly by a skull film. These examinations are made so frequently without careful history. They are too frequently interpreted by doctors not trained in their interpretation that there are many misinterpretations, and there are far too many repetitions of the same already negative examinations.

The last factor in Blue Cross over-utilization which I shall mention is the frequent, unscientific, unnecessary and wasteful use of antibiotics and other expensive drugs.

Both Blue Cross and Blue Shield were originally designed as insurance against the costs of acute illness and accident. Diagnostic and preventive medical and hospital services were, and in most plans still are, not covered. There are three good reasons for this: actuarially, such services are not insurable, because they do not involve risk of loss; to attempt to cover them would make the membership fees too high; and the quality and thoroughness of such services is too variable to demand a uniform professional fee and uinform hospital charges.

Most Blue Cross contracts express the restriction regarding x-ray examinations and other diagnostic tests in some such manner as, "only those examinations consistent with the diagnosis are covered."

The increased costs to Blue Cross because of unnecessary and wasteful utilization are tremendous. In our rather small Blue Cross plan, the elimination of charges for bed and board for the first two days in hospital is expected to result in a saving of over $400,000.00 this year. This deductible feature will serve to deter some from seeking hospitalization for minor illness.

The problems in connection with over and wasteful utilization have been hinted at already. The old American attitude that it is not dishonest to steal from a corporation, with which railroad surgeons have long been familiar, applies here. Neither the patient, nor, in too many instances, the doctor hesitates to make a completely false, a partly false or an ambiguous statement in order to justify Blue Cross benefits. Admission diagnoses are often too ridiculous to be funny, and the ingenuity used in tying-in ancillary services to make

them appear consistent with the diagnosis is frequently remarkable. It is not difficult to record an admission diagnosis even when the primary reason for the admission is to make a diagnostic survey without cost to the patient.

The honest and understanding doctor is penalized. The ordinarily honest doctor, but one who does not familiarize himself with the extent of Blue Cross coverage, and who runs up an unnecessarily big hospital bill expecting the insurance to pay it, is tempted sorely to justify his action in such a way that Blue Cross does pay it. Even hospital management is tempted to side with the patient and his doctor in the matter of an unjust claim rather than to incur ill will and the risk of not being able to collect from the patient.

Already some Blue Cross plans have fixed limits of coverage for ancillary services, and some are restricting service benefits to bed, board, operating room, routine laboratory examinations, inexpensive medicines and general nursing care. As has been indicated, when Blue Cross does that, its coverage is little different from that of commercial companies. It has given up the original Blue Cross concept of assurance for insurance up to fixed cash limits.

Medical directors are frequently accused of attempting to regulate or determine the way in which medicine shall be practiced. The charge is without basis. As a medical director of a Blue Cross plan, I do not care how early you hospitalize your patient, how long you keep him, nor how many unnecessary examinations you order. What I am interested in purely as a medical director is that you and your patient and the hospital understand the extent of the Blue Cross coverage and that you make no attempt by evasion or subterfuge to get more for your patient than what is right and just under the contract. However, as a doctor and as a citizen, I see and deplore the unnecessary extravagance and waste in hospital medical practice. More often than not, it is explained by an unwarranted claim of thoroughness. It is often exercised to satisfy a personal ego—to be a big shot, a great surgeon or diagnostician, with many hospital patients, many x-ray studies, etc. It sometimes results from unwise demands of patients—"I have a pain, take an x-ray picture and see what the trouble is." Such observations are disturbing, particularly in view of the widespread criticism of the high costs of medical care.

Blue Shield suffers from over-utilization in a parallel fashion to Blue Cross, but not to the same degree. Like Blue Cross, Blue Shield requires a waiting period of one year before treatment of pre-existing conditions is covered. Additionally, a variable waiting period is required for certain arbitrarily selected surgical operations. Herniorrhaphies, hemorrhoidectomies and tonsillectomies, operations for relief of conditions which usually do not have a specific and easily recognized time of onset, are subjected to waiting periods by most plans. A waiver of the waiting period may be made in large group contracts. Our plan waives the waiting period in strangulated hernias, strangulated internal hemorrhoids and acutely obstructive, perforating or dangerously bleeding peptic ulcer. Such a waiver, we feel, is in the public interest. Further, these dangerous and often deadly complications cannot be foreseen and application for membership in the plan is not likely to be made in contemplation of their occurrence. However, experience has proven that we, in granting such waivers, have laid the plan open to serious and costly abuses. We have to accept the report of the doctor, when he states that any one of these complications is present. We have paid claims in cases where we had serious reason to doubt the accuracy of the report and to suspect faulty judgment or even deliberate fraud.

We have had to add hysterectomy for fibroids and vaginal and perineal plastic operations to the list of procedures requiring a waiting period. There was too great and variable urgency shown by surgeons in these usually elective and frequently unnecessary operations.

About two-thirds of our Blue Shield contracts include a provision for a cash indemnity for treatment of medical (non-surgical) cases treated in hospital. Therefore, every patient with a minor illness admitted to hospital costs the plan. Further, the indemnity is based on the number of days the patient is visited while

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in hospital. We have had to pay for many social, routine and medically unnecessary visits. Invariably, the physician reports a daily visit to every patient.

Our contract contains a provision that it will not pay both medical indemnity and a surgical fee for concurrent medical and surgical services. However, again in the public interest, we make a non-contractual concession in cases of severe diabetics, who need surgery, those of postoperative pneumonia, serious heart disease and other medical conditions which would seriously jeopardize the outcome of the surgical operation. In such cases we pay both a medical and a surgical fee. However, surgical specialization in our state seems to be so developed, that many of our surgeons will not undertake to treat the simplest medical complication occurring in a surgical patient. We have to be constantly on guard against dual claims for unnecessary concurrent medical and surgical services.

Until recently, we allowed an extra fee for blood transfusions and we found that we were paying $10.00 for many transfusions actually given by interns and nurses. We now allow a fee for blood transfusions only when the transfusion is the primary reason for hospitalization. This is no doubt unfair to the doctor who personally has to give a transfusion. However, abuses by doctors themselves are responsible for the change.

Blue Shield in our state is a mixed service benefit and cash indemnity plan. Only families with incomes not exceeding stated amounts are entitled to service benefits. The plan accepts conditionally the applicant's statement in regard to income. The doctor is not bound to do so. Every doctor probably takes into consideration the financial status of the patient before making a charge. We doctors determine the financial status, either from general knowledge of the patient, the work he does, the house he lives in, the kind of car he drives, or by direct inquiry and investigation. Undoubtedly, we often make mistakes in our estimate — mistakes more often in overestimating income than in underestimating it. Our participating physicians, who are obligated to furnish service benefits to subscribers entitled to them, have been told that the plan will arbitrate any differences which arise between such a physician and a subscriber regarding eligibility for service benefits. Many of our physicians object to undertaking any determination of eligibility. Some have declined to sign participating physicians contracts because of this objection. Others, it has been discovered, bill the patient for the difference between his fee and the fee allowance paid by the Plan, hoping to collect something extra in this way. Should the patient squawk, he pleads bookkeeping error or disagreement as to the income limits of the patient or simply resigns as participating physician.

One final problem. Our plan pays the fee allowance directly to the doctor if he be a participating physician. If not, the check is sent to the subscriber. As would be expected, many of these latter checks never reach the doctor's office. Objection has been raised by doctors who repeatedly refuse to become participating physicians, to the payment directly to the patient. They would have the plan serve as an unpaid and unappreciated collecting agency for them. Our refusal makes for bad physicians relations, and their refusal to become participating physicians makes for bad public relations.

SUMMARY

The basic problems in prepaid sickness insurance stem from the selfishness of people, their desire to get as much as they can for as little money as possible. This selfishness is by no means universal, but it affects some of both the sick layman and the practicing physician. As a result, the fair-minded and scrupulously honest suffer with the selfish and dishonest in an unnecessarily high cost of Blue Cross and Blue Shield membership, in carefully worded and supervised restrictions of benefits, and searching examinations of claims. Until human nature changes, we shall have these problems. However, the Blue Cross-Blue Shield movement, together with commercial sickness insurance, which is a by-product of Blue Cross, is a good thing for the people, the doctors and for hospitals. It is worth preserving—and if it should fail, compulsory government insurance will step into the breach by popular demand.

Editorials

SOME PROFESSIONAL PROBLEMS RELATED TO THE OPERATION OF A TEACHING HOSPITAL

The Board of Trustees and the Faculty of the Medical College of South Carolina have announced the opening of the new and fine teaching hospital—for about July 1. The physical plant and its equipment are matters for justifiable pride by the college and by the state. The primary objective of the expenditure of effort and money, which made the dream of such a hospital realized, is the better training of students of medicine, both graduate and under-graduate. The secondary objective, and a most important one, and one which is closely related to the primary, is to afford the faculty the continuing experience of the practice of medicine, which is so essential for a fulltime clinical teacher. There are also lesser and subordinate objectives which will not be discussed here.

The opening in a community, of a hospital such as the teaching hospital is, always arouses fears, jealousies, and antagonisms on the part of some of those clinical practitioners of the community who are not fulltime teachers in the medical school and on the part of already existing hospitals. It is natural that there should be an element of uncertainty and question and suspicion directed towards the newcomer, backed as it is by the prestige of the medical school and the professors on its faculty. To resolve these uncertainties, questions and suspicions requires exercise of tact and patience and most of all, a spirit of goodwill and understanding by everyone, but most necessarily is it required of the school authorities.

The question as to whether or not the medical school, in operating such a hospital, is corporately entering into the practice of medicine, is academic. Actually, the school is practicing medicine through its salaried faculty, which, in turn, is controlled by its executive officers and its board. However, the two primary objectives of operating the hospital must be constantly kept in mind. The school is directly or indirectly practicing medicine, but not in a competitive spirit nor for gain but solely for educational purposes—to make better doctors and to maintain institutional standards. So long as those primary objectives are kept in mind by everyone concerned, frictions and antagonisms and fears should be kept at a minimum.

Necessarily, the staff of the teaching hospital will be closed, and each member will hold his position by reason of his connection with the medical school. However, that does not mean necessarily that he must be a fulltime, salaried teacher. Such teachers should head the several divisions and departments of the teaching hospital as they do the corresponding departments of the medical school. However, the part-time clinical teachers must have a place on the staff of the hospital, both because of the broadening experience which that will provide them and because of what they, as successful practitioners, can provide in the study and treatment of the patient.

As in every voluntary hospital, patients will fall into three general groups: those who do not pay full hospital costs, those who pay full hospital costs but can afford no professional fee, and those who are able to pay full hospital costs and in addition are able to pay a professional fee. It is the third group which presents problems. The question always arises as to what to do with the professional fees. Medical schools and their hospitals are always in need of money. However, it would not be fair to place these professional fees in the operating budget of the teaching hospital. The hospital should either pay its own way or else additional funds should come from some other source than the medical practice of its staff. Similarly, such fees should not be placed in the ordinary operating budget of the medical school.

Should all professional fees collected be

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divided by some kind of a formula among the members of the hospital staff? A categorical answer cannot be given to that question. Either an affirmative or a negative answer would immediately demand an answer to the question, what kind of a formula should govern the division of fees.

All patients admitted to the teaching hospital will be staff cases. That implies that any member of the staff may be called upon to share in the responsibility of their medical care. This includes non-clinical members of the staff. The part played by any member of the staff in any particular case may vary from nothing to that of a major role. If there is to be a division of professional fees, the non-clinical men should share in the division.

The staff of every teaching hospital should be interested in research. The costs involved in research, however, should not be included in calculation of per diem costs of hospital care. It seems to the writer that a portion of professional fees should probably be diverted to help pay the costs of research projects.

The fulltime salaried teachers should not come into unrestricted competition with local medical practitioners, for two reasons. The first is that they should not benefit in developing a practice by the prestige of professorship on the college faculty. Secondly, if they are allowed to engage in unrestricted practice, they are likely to become more interested and too engrossed in practice as a means of increasing income, with the result that their interest in teaching suffers. However, teachers generally are paid too little, and fulltime teachers in medical schools are paid probably less than half what they could earn in private practice. There seems to be no remedy for this—and perhaps clinical practitioners actually broaden the gap between themselves and fulltime teachers by earning too much money in these inflated times. However, it seems logical to assert that if underpaid, fulltime teachers are required to treat patients, who in turn are required to pay professional fees, then these salaried teachers should share in a division of fees collected, not only as a means of increasing their incomes, but also to compensate in some measure for the expenditure of skill, energy and time, in excess of the requirements of their teaching assignments. Thus, it must be realized that the problem is a very complex one. So far as the writer knows, it has never been solved in a manner satisfactory to all concerned. Any proposed plan is subject to trial and error and change. So far as our own faculty and hospital are concerned, none of us, except, perhaps, the members of the fulltime faculty, need suffer any immediate worry. It will take time to develop the habit of sending patients to our hospital and time for the hospital to develop a widespread reputation which will draw patients to it. Until doctors acquire such a habit and until the hospital develops such a reputation, there will be no great amount of professional fees for division. Once those objectives have been established, the writer sincerely hopes that the professional fees established shall not be allowed to become exorbitant in the way in which it seems to him some other teaching clinics have allowed. A Cadillac costs the rich man no more than it costs the poor one. A Chevrolet furnishes reliable transportation, and it costs the rich man no more than the poor one. There should be an upper limit to charges for any given medical service, without regard to the wealth of the patient. Cadillac services, with the frills of more personalized and pampering attention, are worth more than simply kindly efficient care, but there should be a reasonable limit to charges for the frills.

J. Decherd Guess

VACCINES, SALK AND OTHERWISE

There are a lot of long buried doctors, scientists and intellects whirling in their graves at this moment as they hear of the mass acceptance of Polio vaccination.

The opposition of the people to all mass vaccinations in the past is reminiscent of the attacks of the anti-vivisection groups today.

Where are the anti-polio-vaccination groups? Has the masterful publicity associated with the Salk vaccine results driven them into their fanatic holes?

However much we deplore publicity we

must doff our hats and expose our crew cuts or scalps in admiration for a publicity stunt that outdid the unveiling of the model "A" Ford. It did many things:

It aroused the country. It made us forget what a small percentage of the money collected by the March of Dimes was necessary to effect this wonderful result. It made us overlook the high administrative expense prevalent for years in the March of Dimes. It made us forget that this was the last step in many steps to this perfection. It reminded us that a lot of money and a lot of brilliance exhibited by Jonas Salk proved the value of the anti-polio vaccine several years before it would ultimately have been proved.

It made us remember that Alexis Carrell and Colonel Lindbergh may have had a hand in one step of this advance: they kept a chicken heart alive for years. The monkey kidneys kept alive to produce the anti-polio vaccine well may have been the successors to the chicken heart.

And now, with trumpets, we have the vaccine with which to control a minor but disabling and dramatic disease. Would that the Autocrat of the Breakfast Table were here to comment! Shades of the Shades!

We must keep our feet off the ground and on our desks. The ground trembles with great noises and appropriations. Some of us in many specialties are swelling our chests and making plans. Give Salk his due and his glory and get our feet off this trembling ground. Treat this disease with what is available to us in our usual manner just as we do with typhoid and smallpox: with as little fanfare and as little a fee.

Let us not contribute to the hysteria of discovery. Let the publicists, like the lay executives of all fund raising organizations, have their today; but let us try to control their tomorrow.

We have read in our own Medical Library the writings of our predecessors about preceding vaccines and their efforts to have them accepted. It is a much different story today. Theirs were voices crying for converts and advocates. The historians will find us crying for restraints and orderliness.

Worcester (Mass.) Medical News, May 1955

O T MEANS O T

A highly esteemed contemporary journal[1] has just published an article on a compound designated as "Aerosol O. T.", which appears to have great virtue in constipation. At the same time there has arrived a reprint entitled "O. T. Means Freedom For Parents.[2] No one has disillusioned us about our conviction that O. T. means "Old Tuberculin", and it seems difficult to discern how Aerosol O. T. will work wonders in the bowel, or how that kind of O. T. will help in Occupational Therapy.

This is a mild example of the confusion produced by unexplained abbreviation. The only solution seems to be in some sort of Registry of Abbreviation, or a drastic editorial policy.

Actually, our dictionary definies O T as "old term", but so far, O T means Old Tuberculin to us. For what do you use it?

(1) JAMA: 58: 261
(2) The Crippled Child Feb. 1949

BLUE CROSS . . . BLUE SHIELD

BLUE CROSS - BLUE SHIELD

The resignation of Mr. Allen D. Howland as Executive Director of the South Carolina Hospital Service Plan and of the South Carolina Medical Care Plan became effective on or about June 1. He has served as executive director first of Blue Cross and then of Blue Cross and Blue Shield since they were organized, and it was due largely to his leadership and direction that both plans succeeded so well in their earlier years. During this time, he has received the respect and friendship of a large group of doctors in the state and of the members of the two respective boards, and his personal interest in the affairs of the Plans and his devotion to the ideals of the Blue Cross-Blue Shield philosophy have been steadfast. He was never willing to deviate from that

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philosophy, even when the going got tough and when to deviate towards commercial practice would have been easier.

Mr. Howland has not been well for several months. He suffered an activation of a peptic ulcer, brought on no doubt by the worries and frustrations which came to a head at the annual conference of the Plans, held in April. As executive director, he had to accept the blame for financial difficulties which the annual reports revealed. Blue Cross had failed to improve its financial situation, and Blue Shield had shown an operating loss in 1954. However, he should not be made to accept all of the blame for these facts. Many factors operated together to bring about the unfortunate situation, and the Boards have to accept much of the responsibility for the conditions. Further, the attitude of many doctors and the selfish demands of many members were important factors in producing the situation in which we find ourselves.

Mr. Howland will be missed by many of those with whom he has worked during these years, and many of us hope that he will continue to live amongst us, and we extend him every good wish in his new work.

Mr. Robert J. Koch, Assistant Executive Director of the Michigan Hospital Service Plan, is now acting executive director of our two Plans. He has been cordially received by the members of the two Boards and by the office staff. He comes frankly as a trouble shooter, and he has been carefully selected to help us in our crisis. He will be extended every assistance, but we shall have to look to him for leadership and know-how. He will succeed himself as permanent director in due time, or another suitable man will be found. In the meantime, he will have for his guidance the recommendations made by a management team, sent down to study our situation by the Technical Assistance Board of the Blue Cross Commission. In so far as these recommendations are carried out, they will bring about important organizational changes in the two plans. These will take time and careful planning. The gentlemen who studied our situation have said that we have potentialities in South Carolina that should lead to a growth of one of the strongest Blue Cross - Blue Shield organizations in the south.

J. Decherd Guess, Medical Director
Blue Cross - Blue Shield and
President, Blue Shield Board

NEWS

DR. HARRY S. MUSTARD, HONORARY MEMBER OF THE ASSOCIATION RECEIVES HONORARY DEGREE.

Several years ago, when Dr. Mustard gave much valuable service to the Association in the matter of the proposed rearrangement of the State Board of Health he was made an Honorary Member of this Association, a distinction enjoyed by very few people.

At the Commencement exercises of the Medical College, at which he was the speaker, Dr. Mustard had conferred upon him the honorary degree of Doctor of Public Health, an honor truly deserved.

Dr. Mustard is Professor of Public Health Practice at Columbia University. Born in Charleston, Dr. Mustard is a graduate of Porter Military Academy, the College of Charleston and the Medical College of South Carolina. Following internship at Roper Hospital, he served as an instructor at the Medical College from 1912 to 1920.

He entered public health work in 1920 and was appointed associate professor of public health and

administration at Johns Hopkins University. In 1937, he was named professor of preventive medicine at the College of Medicine at New York University.

He was appointed director of Columbia's school of public health in 1940 and later was named to his professorship at the university. In 1947, Dr. Mustard concurrently served as health commissioner of New York City. He retired from the commission in 1949, and from the directorship of Columbia's school in 1950.

Dr. Mustard is a past president of the American Public Health Assn. and is past editor of the American Journal of Public Health and author of several books on various aspects of public health.

Dr. Henry Heins, Charleston, has passed the Board of Obstetrics and Gynecology.

A meeting of the Eighth District Medical Society was held on May 26 at Dr. Tuten's Pond, Fairfax.

Dr. Francis H. Gay of Columbia spoke on Cerebral Palsy.

DR. EDWARD J. DENNIS JOINS COLLEGE FACULTY

Dr. Dennis was born in Pinopolis, South Carolina. He attended Furman University from 1941-1944. Graduated from the Medical College of South Carolina in 1948. Served his internship at Jersey City Medical Center 1948-1949. He was a Lieutenant (J.G.) United States Navy 1949-1951. Following his discharge from the Navy, he did general practice in Moncks Corner for one year. On July 1, 1952 he began a residency in Obstetrics and Gynecology at Roper Hospital, and completed this residency on June 30, 1955. He will be a full time instructor in Obstetrics and Gynecology at the Medical College beginning July 1, 1955.

ANNOUNCEMENTS

A short intensive course on the laboratory diagnosis and pathology of parasitic infections will be presented August 15-27, 1955 at the Louisiana State University School of Medicine in New Orleans.

The course is designed primarily for pathologists and technologists.

Persons interested in attending this course may write to:

Dr. Clyde Swartzwelder
1542 Tulane Avenue
New Orleans 12, Louisiana

The Annual Meeting of the *Piedmont Post Graduate Seminar* will be held at Clemson House on Wednesday and Thursday, September 14 and 15.

The tentative schedule for these meetings is as follows:

Wednesday, September 14:

3:00 P. M. "The Indications for Caesarean Section", John B. McCain, M. D., Emory University

4:00 P. M. "The Etiology of Subarachnoid Hemorrhage", E. F. Fincher, M. D., Emory University

5:00 P. M. Panel Discussion—"Pancreatic Disease", Albert Vander Kloot, M. D.—"Medical Aspects of Pancreatic Disease", Departmental of Internal Medicine, University of Illinois.

Anton Pantone, M. D.—"X-ray and Laboratory Aspects of Pancreatic Disease", Department of Radiology, Grant Hospital, Chicago, Illinois.

George D. Page, M. D.—"Surgical Aspects of Pancreatic Disease," Charlotte, North Carolina.

6:00-7:00 P. M. Social Hour

7:00 P. M. Banquet—Albert Van der Kloot, M. D. "Congestive Heart Failure."

Thursday, September 15:

3:00 P. M. "Some Aspects of Cardiovascular Surgery", Edward F. Parker, Medical College of South Carolina.

4:00 P. M. Roger A. Harvey, M. D.—Subject to be announced, Professor of Radiology, University of Illinois, College of Medicine.

5:00 P. M. "Some Benign Disorders of the Peripheral Nerves," Bert Sprofkin, M. D., Department of Neurology, Vanderbilt University College of Medicine.

6:00-7:00 P. M. Social Hour

7:00 P. M. Banquet—Roger A. Harvey, M. D.—Rose E. Romer Lecture.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 33rd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 28-September 2, 1955 inclusive, at the Hotel Statler, Detroit.

Scientific and clinical sessions will be given August 29, 30, 31, September 1 and 2. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

Full information may be obtained by writing to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

A full-time eight-week comprehensive course in industrial medicine for physicians will be given in the Post-Graduate Medical School of New York University-Bellevue Medical Center commencing Monday, September 26, 1955 it was announced by Dr. Norton Nelson, director of the Institute of Industrial Medicine.

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Among the subjects being offered to physicians are: organization, administration, and economics of an industrial medical department; the practice of preventive and constructive medicine in industry; the clinical aspects of occupational diseases; industrial injuries and the elements of safety programs; toxicology and industrial hygiene for the physician. Opportunities will be provided for attendance at medical, surgical and clinical pathological conferences during the course.

Applications should be sent to the Dean, NYU Post-Graduate Medical School, New York 16, N. Y. Tuition $250.

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The medical program constitutes 25 hours of formal teaching toward the 150 hours of Post-Graduate study required every three years.

For further medical details address: Director of Post-Graduate Education, Duke University School of Medicine, Durham, North Carolina.

Combined meeting of the South Carolina Chapter of the American College of Surgeons and the annual medical meeting of the staff of the Self Memorial Hospital. The tentative program is as follows:

GREENWOOD — AUGUST 27, 1955

"Management of the Dehydrated Child", Nelson K. Ordway, Head of Department of Pediatrics, L. S. U. School of Medicine, New Orleans, La.

"Immediate Management of the Accident Victim", Moore Moore, Jr., Memphis, Tenn.

"Diagnosis and Treatment of Hematological Malignancies", Wayne Rundles, Professor of Medicine, Duke University, Durham, N. C.

"Surgical Treatment of Carcinoma of the Cervix", W. W. Daniel, Memorial Hospital, New York, N. Y.

"Spontaneous Rupture of the Esophagus", George Bunch, Columbia, S. C.

"Palliative Procedures in Advanced Breast Cancer", Joseph H. Farrow, Memorial Hospital, New York, N. Y.

"Head Injuries", Edgar F. Fincher, Emory University.

"The Ulcer Problem", Philip Thorek, Cook County Graduate School of Medicine, Chicago, Ill.

DEATHS

DR. ROBERT E. SEIBELS

Dr. Robert E. Seibels, Columbia physician died May 30, 1954, aged 64 years.

A native of Columbia, Dr. Seibels had lived there his entire life.

He was a graduate of the University of South Carolina academic school and after his medical training returned to Columbia to practice medicine. He had practiced there since he was a young man.

He was the son of the late Corrie Thompson Seibels and John Temple Seibels. He was a veteran of World War I.

Dr. Seibels was active in fighting cancer. He established the Bob Seibels, Jr., Cancer Clinic in memory of his son, Dr. Robert E. Seibels, Jr., who was killed in a skiing accident.

SOUTH CAROLINIANA

Rectal Strictures of Lymphogranuloma Venereum. Some Observations from a five year Study of Treatment with the Broad Spectrum Antibiotics. Leon Banov, Jr., M. D. Am. J. Surg. 88:761-767, Nov. 1954.

This paper, presented at the 1954 Los Angeles meeting of the American Proctologic Society, reported the clinical observations on the use of the broad spectrum antibiotics in the management of rectal strictures due to lymphogranuloma venereum.

Because there is an inflammatory component in most, if not all, such rectal strictures, the use of one of the broad spectrum antibiotics is indicated.

At this clinic improvement of varying degree was reported by all patients. Objective evidence of improvement was observed in most cases.

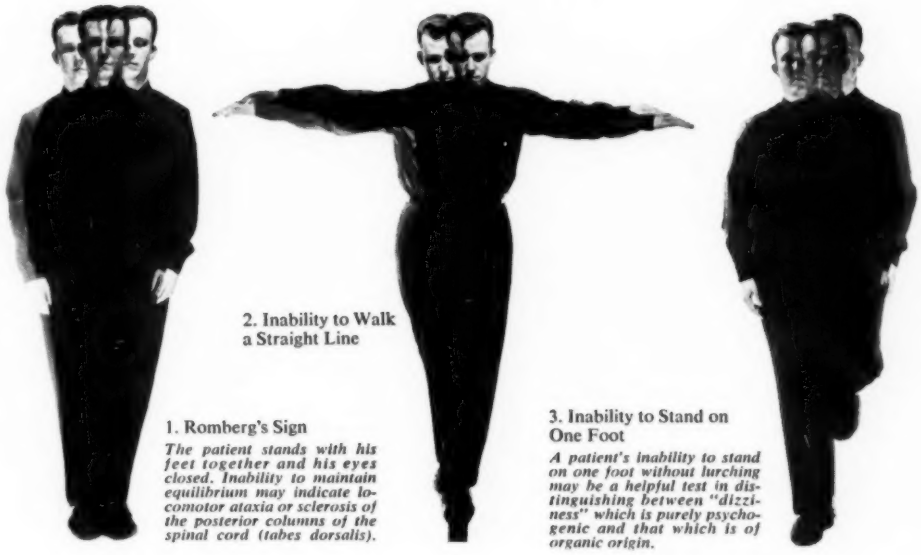
Serial quantitative complement-fixation tests for lymphogranuloma venereum do not appear to be reliable indices for determining adequacy of treatment or of the need for retreatment.

Since the decision to continue treatment with the antibiotics or to re-treat these cases of rectal strictures of lymphogranuloma venereum must be made solely on clinical evidence, there is a definite need for

DRAMAMINE® IN VERTIGO

Notes on the Diagnosis and Management of "Dizziness"

II. False Dizziness



1. Romberg's Sign

The patient stands with his feet together and his eyes closed. Inability to maintain equilibrium may indicate locomotor ataxia or sclerosis of the posterior columns of the spinal cord (tabes dorsalis).

2. Inability to Walk a Straight Line

3. Inability to Stand on One Foot

A patient's inability to stand on one foot without lurching may be a helpful test in distinguishing between "dizziness" which is purely psychogenic and that which is of organic origin.

False dizziness is a sensation of sinking or lightheadedness which is often of psychogenic origin. It should be distinguished from true "dizziness" or vertigo[1] in which there is a definite whirling, moving sensation.

Unsteadiness, lightheadedness and similar manifestations of false dizziness[2] may be psychogenic or the result of arteriosclerosis, hypoglycemia, drug sensitivity and general metabolic disturbances such as anemia and malnutrition. Hypertension is often the cause of these symptoms.

Psychogenic dizziness probably originates at the highest brain centers. It may be described as a sense of uncertainty with occasional mild lurching but not to the point of falling. In these patients there is no nausea, no disturbance of vestibular pathways and otologic and neurologic examinations are negative. The sensation is unaffected by head movement. Symptoms usually disappear[3] with complete rest.

Dramamine® has been found highly effective in many of the conditions already mentioned. Maintenance therapy with Dramamine will often keep the patient from becoming incapacitated by his condition.

Dramamine is also a standard for the management of motion sickness and is useful for relief of nausea and vomiting of fenestration procedures and radiation sickness and for relief of "true dizziness" of other disorders.

Dramamine (brand of dimenhydrinate) is supplied in tablets (50 mg.) and liquid (12.5 mg. in each 4 cc.). G. D. Searle & Co., Research in the Service of Medicine.

1. Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

2. DeWeese, D. D.: Symposium: Medical Management of Dizziness. The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. *58*:694 (Sept.-Oct.) 1954.

3. Kunkle, E. C.: Central Causes of Vertigo, J. South Carolina M. A. *50*:161 (June) 1954.

SEARLE

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PRESIDENT'S PAGE

The Scientific Committee has already started work on the program for the 1956 Myrtle Beach Meeting, which begins May 14. The committee has given much thought to the program and I believe it will be one that all will enjoy.

While attending the AMA Meeting in Atlantic City, I heard Senator Bricker address the Conference of Presidents, and he explained clearly why senate confirmation of treaties is necessary as a safeguard in forestalling socialized medicine. I feel confident that the stand the AMA has taken, and the resolution that has been passed recently by the Greenville County Medical Society are correct, and that every effort should be made to support the Bricker Amendment.

The South Carolina Medical Association has every reason to feel proud of its members for their determination to rid the state of the Naturopathic cult. The Association's members throughout the state have risen as one man, determined that this serious condition be corrected. We have every reason to feel proud of round one. The doctors throughout the state made repeated trips to appear before the Legislature, and did invaluable ground-work in local communities.

The strategy and planning for this cause have been worked out by Council. It is most gratifying that the members have so heartily cooperated. There can be no compromise. We will talk no compromise. We are making a determined effort that the citizens of South Carolina be protected against unqualified and inadequately trained practitioners. Our people deserve the best, and we cannot stand idly by and see an unqualified group practice legally in this state.

During the time until the Legislature meets in January 1956, every opportunity will be made to keep the fires burning. There is reason to believe that the Legislature will overwhelmingly pass legislation repealing the Naturopathic Act with no compromise.

O. B. MAYER, M. D., President
South Carolina Medical Association

clinical criteria for determining adequacy of treatment. Such criteria evolved at this clinic during the past five years have been presented.

A Case Report of Precocious Motherhood. Charles S. McCants, M. D. Tri State Med. J. 3:24 (April 1955)

The most significant item about this case is the child's age. She was born August 1, 1942, a fact confirmed by the birth certificate recorded in the office of the Clerk of Court. There was no obstetrical problem. X-ray revealed a normal pelvis. She had gained from her usual weight of 92 pounds to 111 pounds. Blood pressure ranged from 90 to 108 systolic, 60 diastolic. There was no edema, no dizziness, no nausea, no albumen at any time. The Wasserman was negative. Hemoglobin averaged 76%. Her height was four feet eleven inches, hips thirty-five inches. Her mother states that the patient menstruated twice before she became pregnant. Only medication given was calcium and vitamins and her usual diet was not interrupted. Cesarean section was thought of and preparations made for it; but as results proved, happily was not necessary.

The Surgical Treatment of Primary Varicose Veins. William H. Prioleau, M. D., J. Manly Stallworth, M. D., Charleston. The American Surgeon, 21: 50 Jan. 1955.

The surgical treatment of primary varicose veins is based upon the concept that varicose veins indicate a progressive degenerative disease. The attendant venostasis is due to dilatation of the superficial veins and incompetency of communicating veins with resultant sluggish flow and increased hydrostatic pressure. Treatment is directed toward decreasing the size of the dilated superficial bed and interrupting the incompetent communications between the deep and superficial venous systems. This is best accomplished by classical high ligation of the internal saphenous vein and excision of the subfascial trunks and larger tributaries and plexuses of the internal and external saphenous systems, and ligation of incompetent perforating veins of saphenous and other origin. Open operation is preferable. Stripping is often inadequate, particularly in case of anatomical variations. Injection therapy is contra-indicated due to the danger of uncontrolled thrombosis, which may involve the deep veins. Due to the progressive and generalized nature of the disease, recurrence is always possible. When present it should be treated by the same method.

Carcinoma Arising in Reduplication of the Stomach (Gastrogenous Cyst). Henry W. Mayo, Jr., M. D., E. E. McKee, M. D., and R. M. Anderson, M. D. A Case Report. Ann. Surg. 141:550-555, April, 1955.

METICORTEN
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of sodium retention
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METICORTEN,* brand of prednisone.

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A case is reported of a 64 year old white female who entered the hospital because of weakness and anemia, and was found to have a large filling defect in the lower end of her stomach on a G. I. series.

At operation, this proved to be a reduplication of the stomach (gastrogenous cyst) in which malignancy had developed. She survived radical subtotal gastric resection, and was in good health one year after the operation.

The etiology of reduplication of the stomach was reviewed. It appears that this is the first case of this sort which has been reported.

WOMAN'S AUXILIARY
SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. A. T. Moore, Columbia, S. C. **Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.**

MESSAGE FROM OUTGOING PRESIDENT, MRS. A. T. MOORE

Another year has rolled around, and we are now thinking of convention plans and annual reports. There is still time to accomplish much this year. Our participation in community affairs is an all-year-round job. We must enroll all eligible members in our Auxiliary, work on all projects and support the American Medical Education Foundation. Every physician's family and every Auxiliary member should be a contributor. If possible each member should secure one subscription to Today's Health magazine and one to our National Bulletin.

Today every one is interested in health. The Auxiliary through its state and county units makes an important contribution to the community when it interprets the problems of medical care to the public. Programs must be planned to inform our members on some of the public relation problems facing the medical profession and the ways in which the physicians are solving them. People want to know about medical care, medical costs and medical education. People are interested in the Veterans medical care program relative to non-service connected disabilities. The Auxiliary can function as a tremendous public relations force if individual members are to discuss authoritatively these various subjects when they are under discussion. The Auxiliary meeting is your school; the National Bulletin is your text-book. These are supplemented by the Handbook and your state publication. Today's Health magazine is your means of disseminating authentic health information.

We must heed the lessons of the past but our eyes must be on the present and the future. We may point with pride to our accomplishments but our job is to cement our gains and to reach for new opportunities to serve. The work of the Auxiliary revolves around the American Family and the American Community. You who are active on the community level are closest to the need and you have the greatest opportunity to help preserve and strengthen the family unit through health education.

Our program of helping to maintain and improve health standards calls for education not only of the family of today but the family of tomorrow as well. It calls for education of all lay groups and particularly the education of school children of today who will be the adults of tomorrow. As our membership climbs toward the 800 mark our work and our responsibilities are expanding. We members of the Auxiliary have unusual opportunities to bring our message to members of other women's organizations throughout the state. It is an opportunity we cannot afford to overlook or misuse. Therefore, we must make certain to exercise the art of cooperation to the fullest in order that our results may be the greatest.

We all know that there is a need in every community for health education. It may vary according to the particular problems of each community but our National program is flexible and can be adjusted to local needs. Our task as Auxiliary members is to find where we are most needed and where we can do the most good to further the aims of our parent body. If we do this, we shall be doing our full share.

Mrs. Austin T. Moore, Ex-President
Woman's Auxiliary to the
South Carolina Medical Association

Mrs. V. W. Brabham, Jr.
State A. M. E. F. Chairman
North Boulevard
Orangeburg, South Carolina May 13, 1955

Dear Mrs. Brabham:

I am greatly pleased and gratified by the response from your County Medical Auxiliaries in behalf of the Medical College and for the information that a check for $423.75 has been sent to the National Fund to be earmarked for the Medical College of South Carolina. Please transmit our thanks to those concerned.

Sincerely yours,
Kenneth M. Lynch, M. D.
President, Medical College of South Carolina

The Southern Medical Association, for nearly half a century, has become renowned for its good fellowship and its personal significance to its members. The spirit of fraternity among physicians composing its membership is unequaled—giving the Southern a claim to a friendliness, and *esprit de corps*, which is unique among medical organizations.

The Woman's Auxiliary to the Southern Medical Association was organized in New Orleans, November

25, 1924. It is comprised of the wives of doctors who are members of the Southern Medical Association. There are no dues in the auxiliary; wives automatically become members of the auxiliary when their husbands join the Association whose dues are $10.00 per year which includes the very wonderful Southern Medical Journal published monthly; and there is NO REGISTRATION FEE AT CONVENTION.

The Auxiliary meets just once a year—at the same time and place as the Association.

Southern has three projects: Doctor's Day; Research and Romance of Medicine; Jane Todd Crawford Memorial Student Loan Fund.

Why is Doctor's Day celebrated? In 1935, March 30th was designated as "DOCTOR'S DAY" by the Southern Auxiliary to honor members of the medical profession, both living and dead, this date being selected because in 1842 Dr. Crawford Long of Georgia first successfully used anesthesia. In 1949 the red carnation was adopted as the official flower for Doctor's Day. The day is observed by memorial flowers placed in churches, special dinners, contributions to hospitals and special health projects.

What is Research and Romance of Medicine? This project was adopted in 1930 to preserve the medical history of the South with special emphasis on compilation of biographies of doctors, histories of medical societies and auxiliaries and their projects, nurses and others who have contributed to the progress of medicine.

The Jane Todd Crawford Memorial Student Loan Fund was created in 1928. The Woman's Auxiliary to the Southern Medical Association has named a committee to find ways and means of activating this loan fund. Pertinent information on this fund has been sent to each county president in all southern states and a thorough study has been made by the committee. You are urged to familiarize your membership with the committee's report in order that your councilor may expresss the desires of your state at the next meeting.

The Southern Medical Association and the Southern Medical Auxiliary will hold their convention in Houston, Texas, November 15-17, 1955. Headquarters for women's activities will be at the Rice Hotel. Make your reservations now. Everything is bigger and better in Texas. The hostess auxiliary is going all out to provide for a delightful time for its guests. I had a wonderful time in St. Louis last year and will be looking forward to seeing you in Houston.

Mrs. Jack W. Kennedy
Publicity Chairman
Woman's Auxiliary to the S. M. A.
Arkadelphia, Arkansas

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in rheumatoid arthritis
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than other corticosteroids
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of sodium retention
and potassium depletion
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BOOK REVIEWS

CHRISTOPHER'S MINOR SURGERY, Seventh Edition. Edited by Ochsner, Alton and DeBakey, Michael E. W. B. Saunders Company 1955. Price $9.00.

This old favorite has been widely revised so that, as the editors state, it may be considered virtually a new book. The many collaborators are all members of the teaching staffs of Tulane and Baylor with the exception of two who were formerly associated with those institutions. Thus overlapping of subject matter is avoided while preserving the advantages of experience in particular fields.

The book is eminently practical yet covers a wide field of surgical conditions. The illustrations, many with line drawings, are clear and to the point. The caption of Figure 88 on the depth of burn injury apparently contains a typographical error in that the brackets for degree of burn indicate depth of tissue involved or damaged rather than "destroyed". There is an adequate index and also a list of references to the current literature at the end of each chapter.

The reduced price of nine dollars and the usefulness of this book in daily practice makes it an attractive addition to the library of the student, house officer, and practicing physician.

F. E. Kredel, M. D.

A TEXTBOOK OF PHYSIOLOGY. Seventeenth Edition. Edited by John F. Fulton, M. D. W. B. Saunders Company. Philadelphia and London, 1955. 1275 pp. 600 illus. $13.50.

Most physicians who attended medical school prior to 1946 will recall W. H. Howell's "A Textbook of Physiology" but few will detect any trace of that once familiar work in its present edition, the third under the editorship of John F. Fulton of Yale University. Dr. Fulton, with 12 collaborating editors and some 30 contributors, has transformed the volume into a collection of treatises by specialists. Although clearly conceived with the needs of medical students and physicians in mind, the text is less plentifully supplied with clinical illustrative material but also less limited in its outlook than are some of those which aspire to the presentation of "applied physiology". The editorial policy underlying this is evident in a statement in the preface that the advocates of physiology "still believe that it is a discipline unto itself, yet it must always remain the solid foundation of the medical sciences".

In general the presentations are well balanced, clearly written, adequately documented and authoritative. Inevitably, as in any work with multiple authorship, there are wide variations in literary style and in general attitude, the latter running the gamut from the conservatism characterizing the chapter on vasomotor regulation, and more in accord with the Howell version of the text, to the near revolutionary departure from current textbook presentation exhibited in the chapter on the neurogenesis of respiration. Some readers will feel that the nervous system and special senses are overly emphasized since more than a third of the volume is devoted to these subjects. Possibly a wiser judgment would be that this emphasis has probably not detracted from the value of other sections and that the increased volume of material concerning nervous functions constitutes a bonus prepared under outstanding authorship, including that of Fulton himself who has earned world wide recognition in the field of neurophysiology.

For readers who are already well acquainted with this textbook in its earlier editions, greatest interest will lie in the portions which are new or which have been completely rewritten. These include the sections on body fluids and kidney function, respiration, peripheral nerve and reflex action, and a chapter on acetylcholine and energy transformations in nerve cells.

T. G. Bernthal, M. D.

PUBLIC RELATIONS IN MEDICAL PRACTICE By James E. Bryan, The Williams and Wilkins Co., Baltimore. Price $5.00.

The author has had a long and varied experience with the problems of medicine as a whole and with physicians as individuals in respect to relations with the public, and is adequately entitled to the sound opinions which he expresses. Costs, fee bills, collections, charges and many other pertinent subjects are discussed. There is a great deal in this book from which any doctor can benefit in the conduct of his practice.

The author is very much concerned with the necessity that the doctor be compassionate and altruistic, as well as politic in his contact with his patients and his community. There are many of us who may have forgotten our earlier rules and ethics, and this book may serve to recall us to a better type of relationship with our fellow doctors as well as with the public.

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